Maternal and Child Health Services
Title V Block Grant

State Narrative for Idaho

Application for 2010
Annual Report for 2008

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services and are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2010/ The completed grant application is posted on the Deparment of Healht and Welfare website for public input. The completed application is also provided to Idaho Parents Unlimited (IPUL), a statewide advocacy group for children with special health care needs and their family. Feedback and comments are solicited from staff and families. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ As a result of the 2005 MCH Needs Assessment, the following priorities were identified:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for women and children across provider and community networks.

2. Perinatal Depression. The reorganization of the Department of Health and Welfare resulted in a new division, the Division of Substance Abuse and Behavioral Health.

3. EPSDT Screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring appropriate.

4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.

5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex needs of all CSHCN.

6. Cultural Competency. Division of Health Administrator, Mrs. Jane Smith, RN, is recognizing "Centers of Excellence" within the Division.

7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.

8. Health Education: Strengthen health education in the public schools, including strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing sytem collaboration efforts that focus on outcomes for the MCH population.

10. Overweight and Obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children.

A number of factors over the past year have greatly influenced Idaho's MCH Title V program and the state priorities that were identified in the 2006 application. Below is a list of state priority areas that currently reflect the need of Idaho's MCH population. These are not in priority order; they are presented as a list of 7 key areas needing attention.

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.

2. Public Health will work with Medicaid to explore options to maximize services to the MCH population.

3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.

4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2

years of age.

5. Work with Medicaid, the newly formed Division of Behavioral Health and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.

6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.

7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy.

These seven priority areas encompass the overarching issues and recommendations of the Assessment to strengthen collaborative efforts, system development, collection, review and use of meaningful data and infrastructure building. The priority areas were defined by the Division of Health Administrator, the MCH Director, and the Division of Health Special Projects Coordinator. Data such as immunization rates, as well as existing systems, organization and personnel were considered in selecting the priority areas. The seven areas reflect the areas of need identified by the Assessment for Idaho's MCH program to work on in order to best serve all facets of the MCH population. //2008//

III. State Overview
A. Overview
Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and unhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

Population Information

The 1999 estimated population for Idaho is one million, two hundred fifty-one thousand, seven hundred (1,251,700). Idaho ranks 40th in the United States in population. The increase from 1990 to 1999 of 24.3% was the third highest increase in the nation, after Nevada (50.6 %) and Arizona (30.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.
/2004/ The 2001 estimated population for Idaho is 1,321,006.

/2005/ The 2003 estimated population for Idaho is 1,366,332. Idaho ranks 38th in the United States in population. The increase from 1990 to 2003 of 35.7% was the fifth highest increase in the nation. This population gives Idaho an average population density of 16.26 persons per square mile of land area. Seventeen (17) of Idaho's counties are considered "frontier."//2005//

/2008/ The 2006 estimated population for Idaho is 1,466,465 which is a 13 % increase over the 2000 census. This gives Idaho an average population density of 18 people per square mile. The U.S. average is 85 people per square mile. Fifteen of Idaho's 44 counties are considered "frontier" with fewer than 6 people per square mile. //2008//

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties. /2005/ 34.38 percent of the population in Idaho reside in the rural areas of the state.//2005//

/2005/ Summary of Population by Region (Health District) for 2000
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 250,984 19.40

District 2 100,533 7.77
District 3 191,297 14.78
District 4 344,355 26.61
District 5 162,397 12.55
District 6 156,906 12.13
District 7 160,132 12.38

/2005/ Summary of Population by Region (Health District) for 2003
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 265,672 19.44
District 2 100,348 7.34
District 3 213,465 15.62
District 4 369,002 27.01
District 5 167,444 12.26
District 6 158,266 11.58
District 7 168,969 12.37
//2005//

/2007/ Summary of Population by Region (Health District) for 2005
(July 1, 2005 Census Estimate)

DISTRICT	POPULATION	PERCENT
District 1	201,570	14.1%
District 2	100,465	7.0%
District 3	227,825	15.9%
District 4	389,228	27.2%
District 5	170,617	11.9%
District 6	162,342	11.4%
District 7	177,049	12.4%

//2007//

/2007/ Summary of Population by Health District for 2006
Idaho Population Estimates, July 1 2006

District	Population	%
Idaho	1,466,465	
1	206,140	14.1%
2	101,195	6.9%
3	237,246	16.2%
4	403,626	27.5%
5	173,626	11.8%
6	163,022	11.1%
7	181,610	12.4%

Source: Census Bureau, Internet release March 22, 2007. //2008//

/2009/
Population Estimate July 1, 2007
Source: Census Bureau, Internet release March 20, 2008

District	Population Count	%	
Idaho	1,499,402	100.0	
1	208,445		13.9

2	102,388	6.8
3	243,156	16.2
4	418,778	27.9
5	174,057	11.6
6	162,880	10.9
7	189,698	12.7

//2009//

/2010/
Population Estimate July 1, 2008
Source: Census Bureau, Internet release March 20, 2009

District	***Population Count***	***%***
Idaho	***1,523,816***	***100.0***
1	***211,870***	***13.9***
2	***102,099***	***6.7***
3	***248,000***	***16.3***
4	***426,283***	***28.0***
5	***176,400***	***11.6***
6	***164,357***	***10.8***
7	***194,807***	***12.8***

//2010//

Ethnic Groups

The estimated racial groups that comprised Idaho's population in 1999 were: (a) white, 96.9%; (b) black, 0.60%; 8 native American/Eskimo, 1.33%; (d) Asian/Pacific Islander, 1.15%. Hispanics make up 7.4% of the race categories. More than half of Idaho's Hispanic population resides in two regions (health districts), with 32.5% residing in Health District 3 and 20.4% in Health District 5. The majority of the Native Americans resides on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

/2007/ Population Estimate, July 1, 2004
Percent of Total Population Estimate in District by Race and Ethnicity

		Race				Ethnicity
	Total	White	Black	American Indian	Asian and Pacific Islander	Hispanic or Latino*
Idaho	100.0%	96.4%	0.7%	1.6%	1.3%	8.9%
District 1	100.0%	97.2%	0.4%	1.9%	0.6%	2.5%
District 2	100.0%	94.6%	0.5%	3.5%	1.3%	2.1%
District 3	100.0%	97.0%	0.6%	1.2%	1.1%	18.1%
District 4	100.0%	95.6%	1.3%	0.9%	2.3%	5.8%
District 5	100.0%	97.9%	0.5%	0.9%	0.7%	16.7%
District 6	100.0%	94.7%	0.6%	3.8%	0.9%	8.2%
District 7	100.0%	97.9%	0.6%	0.7%	0.8%	8.0%

*Persons of Hispanic or Latino ethnicity may be of any race and are included in the appropriate race totals.

Source: National Center for Health Statistics. Estimate of July 1, 2004 resident population from the Vintage 2004 postcensal series by state, county, year, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; Internet release September 9, 2005.//2007//

/2009/
July 1, 2006 Estimate by Race and Ethnicity*
Idaho Districts and Counties

	RACE					ETHNICITY
	White	Black	American Indian	Asian or Pacific Islander		
RESIDENCE	TOTAL					Non-Hispanic Hispanic
IDAHO	1,466,465	1,410,951	12,681	22,909	19,924	1,327,595	138,870
(percent)	96.2%	0.9%	1.6%	1.4%	90.5%	9.5%	
District 1	206,140	200,128	843	3,808	1,361	200,146	5,994
(percent)	97.1%	0.4%	1.8%	0.7%	97.1%	2.9%	
District 2	101,195	95,163	658	3,637	1,737	98,690	2,505
(percent)	94.0%	0.7%	3.6%	1.7%	97.5%	2.5%	
District 3	237,246	229,617	2,037	2,908	2,684	193,081	44,165
(percent)	96.8%	0.9%	1.2%	1.1%	81.4%	18.6%	
District 4	403,626	384,133	6,175	3,722	9,596	377,825	25,801
(percent)	95.2%	1.5%	0.9%	2.4%	93.6%	6.4%	
District 5	173,626	169,795	754	1,679	1,398	142,540	31,086
(percent)	97.8%	0.4%	1.0%	0.8%	82.1%	17.9%	
District 6	163,022	154,375	1,108	5,877	1,662	148,769	14,253
(percent)	94.7%	0.7%	3.6%	1.0%	91.3%	8.7%	
District 7	181,610	177,740	1,106	1,278	1,486	166,544	15,066
(percent)	97.9%	0.6%	0.7%	0.8%	91.7%	8.3%	

* Race and Hispanic origin are reported separately. Persons of Hispanic origin are included in appropriate race totals.
Source: Bridged Race Population Estimates, National Center for Health Statistics, estimates of the July 1, 2006, United States resident population from the Vintage 2006 postcensal series, prepared under a collaborative arrangement with the U.S. Census Bureau, Internet release date August 16, 2007. //2009//

/2010/Population Estimate, July 1, 2007

Total	***Race***				***Ethnicity***	
RESIDENCE	***White***	***Black***	***American Indian***	***Asian or Pacific Islander***	***Not Hispanic or Latino***	***Hispanic or Latino***
Idaho	***1,499,402***	***1,436,908***	***16,854***	***23,697***	***21,943***	***1,351,976***	***147,426***
District 1	***208,445***	***201,748***	***1,244***	***3,915***	***1,538***	***202,001***	***6,444***
District 2	***102,388***	***96,235***	***749***	***3,656***	***1,748***	***99,834***	***2,554***
District 3	***243,156***	***234,019***	***2,920***	***2,991***	***3,226***	***196,576***	***46,580***
District 4	***418,778***	***396,009***	***8,085***	***4,065***	***10,619***	***389,718***	***29,060***
District 5	***174,057***	***169,830***	***1,029***	***1,721***	***1,477***	***142,190***	***31,867***
District 6	***162,880***	***153,795***	***1,333***	***6,015***	***1,737***	***148,254***	***14,626***

District 7 //2010//	***189,698***	***185,272***	***1,494***	***1,334***	***1,598***	***173,403***	***16,295***

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain. /2005/ A study of migrant and seasonal farm workers is currently being conducted. The report should be complete by Spring 2005. //2005//

Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1997-1999) median income in Idaho ($36,023) was 9.2% lower then the national average ($39,657). The number of children under 18 living in poverty varies greatly by county from the lowest (9.1%) in Blaine County to highest (31.2%) in Shoshone County. The statewide average is 16.5%. Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1997-1999), there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 53,000 of these children come from households that lack health insurance.

/2005/ Census data for 2000-2002 indicates there are approximately 393,000 children under the age of 19 living in Idaho. Approximately, 165,000 reside in households earning incomes at or below 200% of poverty level. It is estimated that 35,000 of these children come from households that lack health insurance.//2005//

/2009/ In 2005, 45% of all Idaho children lived in families with incomes below 200% FPL or $40,000 annual income for a family of four. This compares with a national rate of 40%. The statistics are worse for children under age five (48%) and Latino children (75%) living in low-income families. In 2005, 28% of children lived in low-income, working families which earns Idaho a ranking of 45th in the nation. Approximately 17.5% of all idaho children, 0 to 18 years of age, live below the FPL of $20,000 annual income for a family of four. //2009//

Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96; and remained stable at 91.1% in the 1998-99 school year. Idaho's 1999 - 2000 school dropout rate among 16-19 year-olds dropped to 6 percent.

/2005/ Idaho's 2002-03 dropout rate among 16-19 year olds dropped again to 3.88 percent. //2005//

/2007/ In 2004, 36.6 percent of people in Idaho 18 to 24 years of age have completed high school (including equivalency). In 2004, 87.3% percent of people 25 years and over in Idaho had completed high school (including equivalency) ranking Idaho 18th.//2007//

/2009/ In 2004 an estimated 30% of 3 to 4 year olds in Idaho attended a preschool program compared to a national rate of 45%. Idaho is one of only 10 states that does not provide a state funded pre-kindergarten program. Idaho does not provide any state funding for Head Start.

Approximately 31% of the eligible population of 3 to 4 year olds in Idaho receive Head Start services. Minimally, 10% of Head Start / Early Head Start enrollment is reserved for children with special needs. During the 2006 -- 2007 program year, 606 Idaho children with special needs were served through Head Start / Early Head Start. //2009//

Health Delivery System in Idaho

As a frontier state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance for program implementation, planning health care systems and infrastructure. Serving distinct populations such as migrant/seasonal farm workers, children with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery is comprised of the following elements:

A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems.

/2007/ Statewide care coordination is provided for uninsured CSHCN through a contract with St. Luke's Regional Medical Center's Children's Specialty Center. Monthly pediatric and quarterly adult CF clinics are held at St. Luke's, and metabolic clinics are held quarterly at the state laboratory in Boise and twice annually at two district health departments. //2007//

/2009/ Statewide care coordination is provided for uninsured CSHCN through a contract with St. Luke's Regional Medical Center's Children's Specialty Center. Monthly pediatric and quarterly adult Cystic Fibrosis clinics are held at St. Luke's. Regional metabolic clinics are held four times per year in northern and eastern Idaho. CSHP also provides financial support for quarterly cleft lip & palette clinics in Northern Idaho, and for several (more than one per month) clinics in Eastern Idaho serving patients with a variety of birth defects. //2009//

/2010/In October of 2008 the Children's Special Health Program entered in to a contract with St. Luke's Hospital to also provide additional specialty clinics at the Children's Specialty Center. Genetics clinics are now held three days per month, and metabolic clinics are held three days per quarter, at St. Luke's. Regional metabolic clinics continue to be held four times per year at Health Districts in northern and eastern Idaho. CSHP also provides financial support through Health Districts for quarterly cleft lip & palette clinics in Northern Idaho, and for several (more than one per month) clinics in Eastern Idaho serving patients with a variety of birth defects.//2010//

B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division

licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.

/2010/ Public health preparedness activities for the state are also coordinated through the Division of Health. //2010//

C. In 2000, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,082. /2005/ Bed capacity has increased to 3,326.//2005//

/2010/ There are currently 52 licensed hospitals in the state with a total bed capacity of 3,570. //2010//

D. There are 23 Community and Migrant Health Centers in Idaho which served 59,823 patients in 2000 with 213,241 encounters. There also are 35 certified rural health clinics, and 5 registered free medical clinics.

/2005/ There are 24 Community and Migrant Health Centers in Idaho which served 64,714 patients in 2002 with 234,101 encounters. There also are 43 certified rural health clinics, and 7 registered free medical clinics.//2005//

/2007/ There are 10 Community and Migrant Health Centers (organizations) in the state, but many of them have satellite clinics. It is perhaps more accurate to say there are 10 Idaho organizations serving 34 communities (including three communities in Oregon). The 330 grantees aggregately served 88,932 patients in 2005, with 329,228 total encounters (this includes medical, mental health, substance abuse and dental). It also includes 9,255 encounters for "enabling services" (case managers, health educators).//2007//

/2009/ Idaho is served by twelve Community Health Centers with over thirty-three clinic sites that offer primary and preventive care. Dental and mental health behavioral services are also offered at many of these locations. In 2006, Idaho's Community Health Centers served the medical requirements of over 92,000 patients. //2009//

E. As of March 2001, there were 2,290 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 182 physicians providing patient care per 100,000 population. As of April 2001, there were 1,208 primary care physicians in Idaho. The ratio of primary care physicians per 100,000 population is 96.

/2006/ As of May 2005, there were 685 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice, General Practice, Obstetrics, Gynecology, Ob-gyn, Pediatrics and General Internal Medicine as their primary specialties.) There were a total of 308 Physician Assistants, 29 Certified Nurse Midwives, 441 Nurse Practitioners and 1,073 Pharmacists licensed and practicing in the state. It is also practical to note that there are 254 licensed Community Pharmacies in Idaho. There were 810 Physical Therapists, 297 Occupational Therapists (and 98 Occupational Therapy Assistants), 57 Psychiatrists and 687 Dentists licensed and serving Idahoans. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2006//

/2007/ As of May 2006, there were 1,170 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice 592, General Practice 31, Ob-gyn 140, Pediatrics 131 and General Internal Medicine 276 as their primary specialties.) There were a total of 352 Physician Assistants, 21 Certified Nurse Midwives and 289 Nurse Practitioners. There are approximately 1,700 Pharmacists licensed with the State of Idaho, 1,400 of whom are practicing in the state. It is also practical to note that there are approximately 250 licensed Community Pharmacies in Idaho. There were 846 Physical Therapists, 316 Occupational Therapists (and 98 Occupational Therapy Assistants), 96 Psychiatrists and 716 General Dentists licensed and

serving Idahoans, and 884 total licensed Dentists in Idaho. There are 882 active-status licensed Dental Hygienists in Idaho. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2007//

/2009/ As of May 2008, there were 1,203 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice 584, General Practice 28, Ob-gyn 142, Pediatrics 142 and General Internal Medicine 307 as their primary specialties.) There were a total of 441 Physician Assistants, 24 Certified Nurse Midwives and 511 Nurse Practitioners. There are 1,835 Pharmacists licensed with the State of Idaho practicing in the state. It is also practical to note that there are 274 licensed Community Pharmacies in Idaho. There were 902 Physical Therapists, 221 Physical Therapy Assistants, 357 Occupational Therapists (and 103 Occupational Therapy Assistants), 99 Psychiatrists and 789 General Dentists licensed and serving Idahoans, and 947 total licensed Dentists in Idaho. There are 1,081 active-status licensed Dental Hygienists in Idaho. These numbers represent whole counts made available through State Licensure Boards and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2009//

/2010/ House Bill 185 requiring the licensure of midwives was passed.

F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 2000. These clinics provide a wide variety of preventive health services to Native Americans.

/2009/ There continues to be five Tribal Health Service clinics operating in Idaho. There is a clinic serving each of the federally recognized tribes in Idaho. Each of these tribes is also a delegate to the Northwest Portland Area Indian Health Board. //2009//

G. Health Maintenance Organization (HMO) penetration rate for Idaho is estimated at 7%.

An area of concern facing Idaho is its aging health professional workforce. Ranked one of the "oldest" in the nation (second only to Wyoming), the state's population is growing at a much faster rate than the health care professional workforce in primary care. Doctors and dentists are retiring more quickly than medical graduates are replacing them. Idaho does not have a medical or dental school to contribute to this much needed workforce.

Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1997 - 1999, there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. Most of those children below 200% are covered by some form of health insurance; however, approximately 29.3% (53,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who did not have health insurance in 1998. According to FY 2000 BRFSS survey data, 13% of Idaho households contained uninsured children.

/2005/ An estimated 16.8% of the state's population, over 225,600 individuals, have no health insurance (age 18-64, 2002 BRFSS data.) That equates to 1 out of every 6 adults not having health care coverage.//2005//

/2009/ In 2006, 18.8% of adults 18 years and older in Idaho had no health care insurance. The majority (58.9%) of Hispanics in Idaho were without health care coverage. This

compares with 15.5% of non-Hispanic Idahoans. Those without health insurance coverage were more than five times as likely as the insured to say they needed to see a doctor in the past year but could not because of cost (43.8% compared with 8.5%). //2009//

/2010/ In 2007, the percent of adults in Idaho with no health insurance remained level at 18.9%. 39.4% of Idahoans with incomes below $25,000 reported being without health insurance. This compares with 11.3% for those with incomes of $25,000 or higher. //2010//

Utilization of Medicaid is very low in Idaho compared to the rest of the nation. Less than 9% of Idaho residents are Medicaid recipients, compared to 12.6% of the U.S. population enrolled in Medicaid. Additionally, the 1998 Idaho State Child Health Plan Under Title XIX for the State Children's Health Insurance Program estimated that only about 60% of children eligible for Medicaid in Idaho are actually enrolled in the program.

/2005/ Many communities in Idaho, especially those in rural and frontier areas, are considered underserved. Idaho ranked 49th in the country in 2002 for number of primary care physicians per 100,000 civilian population. As of 2002, the ratio of primary care physicians per 100,000 population was 68. Currently 80.6% of the state's area has a designation as a health professional shortage area in primary care, 74.3% in dental health, and 100% in mental health (Figures 1, 2 and 3). Access to care in rural areas is especially variable. Providers are usually clustered in small communities but care for residents whose homes are scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel, health workforce recruitment challenges, deepening fiscal problems of rural health care facilities, as well as by fragile EMS systems that often serve as first encounter points for direct care. Poverty level and low-income populations face exceptional problems in accessing primary care. An estimated 16.8% of the adult population (age 18 to 64, 2002 Idaho BRFSS data) does not have health insurance, and even more are considered to have "insufficient coverage". An estimated 45% of Idaho adults age 18 to 64 do not have dental insurance (2002 Idaho BRFSS data). Other barriers include language, cultural, transportation and geographic factors.//2005//

/2006/ Currently, 88.4% of the state's area has a designation as a health professional shortage area in primary care, 88.7% in dental health, and 100% in mental health (Figures 1, 2 and 3).//2006//

/2007/ According to the Morgan Quitno Press, Health Care State Rankings 2006, Idaho ranked 50th for "rate of physicians in 2004" with 193 per 100,000 population. Idaho ranked 49% for "rate of physicians in patient care in 2004" with 161 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2005" with a reported 17.9%. Currently, 90.0% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.9% in Dental Health, and 100% in Mental Health.//2007//

/2008/ According to the Morgan Quitno Press, Health Care State Rankings 2007, Idaho ranked 49th for "rate of physicians in 2005" with 198 per 100,000 population. Idaho ranked 49% for "rate of physicians in patient care in 2005" with 162 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2006" with a reported 18.0%. Currently, 95.3% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.4% in Dental Health, and 100% in Mental Health.//2008//

/2009/ According to the CQ Press, Health Care State Rankings 2008, Idaho ranked 49th for "rate of physicians in 2006" with 200 per 100,000 population. Idaho ranked 49th for "rate of physicians in patient care in 2006" with 162 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2007" with a reported 16.9%. Currently, 96.7% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 93.9% in Dental Health, and 100% in Mental Health.//2009//

/2010/ According to the CQ Press, Health Care State Rankings 2009, Idaho ranked 50th for

"rate of physicians in 2007" with 200 per 100,000 population. Idaho ranked 49th for "rate of physicians in patient care in 2007" with 160 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2008" with a reported 17.4%. Currently, 96.7% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 93.9% in Dental Health, and 100% in Mental Health.//2010//

The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. As a result, services such as those provided for reproductive health through contracts by the Title V agency are provided in only 37 (occasionally 38) of the 44 counties in Idaho. The counties without services are the most isolated and those with the lowest populations such as Camas county, population 844, and Clark county, population 906. Providing services to frontier counties that have clinic sites is challenging. For example, staff must travel from Idaho Falls (Bonneville County) to Salmon and Challis, Idaho, (Lemhi County) once a month to provide clinic services. This is a 368 mile journey that requires three nights of motel expenses, four days per diem expenses, and 7 to 10 travel hours. All travel is on two lane roads, and driving conditions are often hazardous in winter.

/2007/ According to the July 2005 population estimates, U.S. Census Bureau, the population of Camas County is now 1,050 and the population of Clark County is 943. Camas County now has services in Fairfield. Clark County does not have services.//2007//

There are 23 community/migrant clinic sites in Idaho. All but one is in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. /2004/ There are now 2 community/migrant clinics in north Idaho.

/2005/ There are 24 community/migrant clinic sites in Idaho. All but three are in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. There are now 2 community/migrant clinics in north Idaho.//2005//

/2007/ The Bureau of Facility Standards lists 47 certified rural health clinics. There are nine free medical clinics registered with the State of Idaho.//2007//

/2005/During 2003, two new community/migrant dental clinics opened in southwest Idaho and a third added a dentist. In north Idaho, one such dental clinic has been expanded and efforts are underway to establish dental clinics at the two new community health centers. A mobile dental clinic, with 1-2 dentists providing care onsite has been operating in north Idaho in partnership with the District Health Department. During 2003, 7,600 patients were served via 18,000 dental visits at 7 onsite community health center dental clinics staffed by 7.5 FTE dentists. As of November 2003, there were 10.6 FTEs with 2 vacancies.//2005//

Oral Health

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. Through the Children's Health Insurance Program (CHIP) outreach efforts, 29,829 children have been enrolled in Medicaid and CHIP since November 1999, bringing the total to over 90,000 as of April 2001. These children will likely have poor access to dental services because in 1999, only 27.9 percent of the enrolled children had a dental visit or service. The picture does not get any brighter with an American Academy of Pediatrics' estimate that an additional 55,000 to 75,000 children in Idaho are medically uninsured. The Surgeon General's Report on Oral Health in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance.

/2007/During SFY 2005, there were 104,041 children enrolled in Title XIX Medicaid for at least

one month of the year and another 12,458 children enrolled in the Medicaid expansion Title XXI CHIP A and CHIP B.//2007//

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-three of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of March 2001, there were 709 active licensed dentists statewide. During state fiscal year 2000, the toll-free Idaho CareLine averaged 388 calls per month from persons seeking a Medicaid dentist. From July 2000 through February 2001, the CareLine received 4,061 calls for a Medicaid dentist and another 150 calls from persons seeking free or reduced fee dental services. In December 2000, CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 94 dentists responded that they were.

/2009/ During SFY 2007, the toll-free Idaho CareLine averaged 234 calls per month from persons seeking a Medicaid dentist, down 19 percent from 2006. Calls totaled 2,812 seeking a Medicaid dentist and 792 persons called seeking free or reduced dental services.//2009//

/2007/ During SFY 2005, the toll-free Idaho CareLine averaged 331 calls per month from persons seeking a Medicaid dentist, down 27 percent from 2005. Calls totaled 3,969 seeking a Medicaid dentist and 741 persons seeking free or reduced dental services. A total of 567 dentists (64%) of 884 dentists with an Idaho license and in-state address had one or more paid Medicaid claims and 325 (57%) of Medicaid billing providers had paid claims of $10,000 or more. Five Idaho counties are without a dentist and 11 counties have no Medicaid billing dentist who saw 50 more beneficiaries under age 21.//2007//

/2006/ During SFY 2004, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist, up 86 percent from 2003. Calls totaled 5,459 seeking a Medicaid dentist and 602 persons seeking free or reduced dental services.//2006//

/2005/ During state fiscal year 2003, the toll-free Idaho CareLine averaged 244 calls per month from persons seeking a Medicaid dentist. From July 2002 through June 2003, the Idaho CareLine received 2930 calls for a Medicaid dentist and another 431 calls from persons seeking free or reduced fee dental services. In April 2002, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 75 dentists responded that they were.//2005//

/2004/ During state fiscal year 2002, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist. From July 2001 through June 2002, the CareLine received 5,455 calls for a Medicaid dentist and another 293 calls from persons seeking free or reduced fee dental services. In April 2001, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 90 dentists responded that they were.

During federal fiscal year 2001, 122,526 children were enrolled in the combined Medicaid/ Children's Health Insurance Program (CHIP) and 29 percent had a dental visit or service. In FFY 2002, the number enrolled increased to 133,479, but the number of children who received any dental services decreased to 19 percent. According to the 2003 Idaho Kids Count Book, 28 percent of Idaho children under age 18 are without health insurance coverage, up from 18 percent in 1994, and an estimated 29,600 Idaho children under age 19 years are eligible but not yet enrolled in CHIP.

/2006/ During SFY 2004, the average monthly enrollment of eligible children in Title XIX Medicaid was 100,520 and 11,235 in Title XXI CHIP.//2006//

/2005/ The number of children insured through Medicaid and CHIP grew 154 percent between 2000 and 2003. In 2003, 33% of eligible children age 21 or younger and 21% of children age 1-5

years received a dental visit or service, an increase of 14% and 11% respectively over 2002.//2005//

As of June 2002, there were 767 active licensed dentists statewide, with 552 (72%) enrolled as Medicaid providers. Fifty percent were significant providers, receiving $10,000 or more in annual Medicaid payments. During state fiscal year 2002, the toll-free Idaho CareLine averaged 479 calls per month from persons seeking a Medicaid dentist or free/reduced fee dental services. From July 2002 through March 2003, the number of calls to the CareLine dropped to an average of 268 per month, reflecting public awareness that adult Medicaid dental benefits had been reduced to emergency care only. CareLine staff periodically calls each Idaho dentist with an active license to determine if they are accepting new Medicaid patients. As of March 2003, 11 of 44 counties had no dentists accepting new Medicaid patients and 7 counties had no dentists who accept Medicaid.

/2005/During 2003, there were 772 dentists and 769 dental hygienists with an Idaho license and in-state address. Ninety-one percent (705) of dentists were enrolled as Medicaid/CHIP providers, but only 59% (413) had one or more paid Medicaid claims in 2003. Dentists with paid Medicaid claims > $10,000 numbered 182 (26%); 11 of 44 counties had no dentists in this category. Currently, 30 of Idaho's 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area.
//2005//

/2006/ As of July 2004, there were 807 active licensed dentists with Idaho addresses; 563 (69.8%) dentists had at least one paid Medicaid claim and 319 (39.5%) had paid claims > $10,000, a substantial increase over 2003. Four of the 44 counties had no enrolled Medicaid dentist. //2006//

/2009/ With Medicaid reform and an emphasis on preventive health, Medicaid recipients now receive preventive dental visits through the Idaho Smiles dental plan. //2009//

Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services. We continue to pursue an

enhancement of Medicaid for family planning services, which will reduce unintended pregnancy and improve the well being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births. No decision has been made to date. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program (CSHP). We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

/2005/ We are no longer pursuing TANF funds for family planning activities. We are working to expand options under Medicaid to allow coverage for family planning services for two years postpartum for women to improve preconception health and assure adequate spacing of births.//2005//

The Idaho Children's Health Insurance Program, CHIP, was implemented in October 1997 as a Medicaid expansion to take advantage of federal matching funds targeted to making health insurance available for uninsured children in families with limited incomes. Federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's task force was appointed to study and make recommendations on the long-term design for the program. Their report was delivered to the Department in November 1998 for review and submission to the new Governor and Legislature.

In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering committee to revisit the citizen's task force recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Bureau of Health Policy and Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21 recommendations to the oversight committee in September 1999. The oversight committee made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts.

/2009/ Medicaid has developed a 2 page child only application form to simplify the enrollment process. This form is being piloted in the Children with Special Health Care Needs clinics. //2009//

At the writing of the 2001 MCH Block Grant application, the importance of outreach to CHIP enrollment had been recognized and was made a top priority in the regional offices as well as the central office. The Department of Health and Welfare's aggressive campaign to identify children eligible for CHIP resulted in identifying four times as many who qualify for Medicaid. After starting out slowly with just a few hundred children in 1997, CHIP participation skyrocketed over the next two years to more than 10,000 children. At the same time, the promotional effort had been credited with uncovering tens of thousands of new Medicaid participants. However, in an effort to curb the growth of the Medicaid budget, the State Legislature voted to cap the CHIP program as well as limit recruitment.

Analysts say the state would meet the federal promotional requirement by simply issuing a brochure. Ultimately, the legislature extended restrictions on promoting program participation to all state health and social service programs. How this mandate will impact program services remains to be seen.

Idaho's current Governor has declared this the "Generation of the Child", and in doing so, has established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24-month-old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with Scientific Technologies Corporation to develop a plan for the implementation of the immunization registry, the immunization reminder information system (IRIS). The registry is now operational and has been for over two years. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

/2004/ The number of providers providing vaccination data to IRIS increased to 129. To date there are over 195,000 patient records and over 2,000,000 vaccination records. All but 43,667 of the vaccination records are for individuals 18 and younger.

/2005/ As of 6/10/04: 203 Health Care Providers, 554 Schools and Daycares are enrolled 220,316 patient records and 2,527,407 vaccinations. 162,514 records are 18 and younger, 57,802 are over 18.//2005//

/2006/ As of 6/10/05: 253 Health Care Providers, 758 Schools and Daycares are enrolled in IRIS. 265,228 patients total, 3,124,787 vaccinations. 190,712 records are 18 and younger, 74,516 are over 18.//2006//

/2007/ As of 05/29/06: 276 Health Care Providers, 903 Schools and Daycares are enrolled in IRIS in Idaho and 7 providers from border areas in Washington State are also enrolled. 297,554 patients total, 3,739,209 vaccinations. 290,734 records are 18 and younger, 85,422 are over 18. 93% of all Idaho newborns are consented into the Idaho Immunization Registry. Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2007//

/2008/ As of 05/25/07: 298 Health Care Providers, 1,019 Schools and Daycares are enrolled in IRIS in Idaho and 8 providers from border areas in Washington State are also enrolled. 335,911 patients total, 4,290,900 vaccinations. 237,834 records are 18 and younger, 98,077 are over 18. 94% of all Idaho newborns are consented into the Idaho Immunization Registry. We track this differently now so I don't know what you want to include-we know for 2006 that 87% of newborns submitted to vital stats are also consented for IRIS. According to the daily status in IRIS, we currently have 20,231 children under the age of 1 year in IRIS so additional children are being added after being in the hospital. Are we still using 20,000 for the birth cohort or 21,000? Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2008//

/2009/ As of 05/23/08: 298 Health Care Providers, 798 Schools and Daycares are enrolled in IRIS in Idaho and 8 providers from border areas in Washington State are also enrolled. 373,236 patients total, 4,927,664 vaccinations. 264,747 records are 18 and younger, 108,489 are over 18. 94% of all Idaho newborns are consented into the Idaho Immunization Registry. According to the daily status in IRIS, we currently have 20,863 children under the age of 1 year in IRIS so additional children are being added after being in the hospital. Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to

implement a new data quality assessment component during 2008-2009.//2009//

Another recent initiative within the state is an effort to better coordinate health services to clients. This is exemplified by the vision statement of the Idaho Department of Health and Welfare's new "Strategic Plan 2001 - 2004" which is to Provide leadership for development and implementation of a sustainable, integrated health and human services system. While the plan is obviously intended for the entire population of Idahoans, its vision, goals and objectives describe an approach consistent with the MCH needs assessment/performance measure model used in the current block grant. Every four years, the Department will collect and compile health and safety data, prioritize health and safety issues based on this data, and develop strategies, set expected outcomes measures and identify resources. Following that process, there will be an evaluation of the impact of strategies on improving the status of health and safety priorities. Other features of the plan call for identification of family and community resources necessary to support the wellbeing of Idahoans and identification and application of models of cooperative relationships to support an integrated and sustainable health and human services system.

/2009/ The 2007-2011 Department Strategic Plan is comprised of three goals: 1) Improve the health status of Idahoans; 2) Increase the safety and self-sufficiency of individuals and families; and 3) Enhance the delivery of health and human services. A separate, but integrated Department Customer Service Plan was put forth in October 2007. The customer service standards -- the 4 c's -- are caring, competence, communication, and convenience. //2009//

/2004/ The Department is currently in the process of designing an Any Door initiative to ensure clients are linked with needed services. This will include all services offered by the Department of Health and Welfare and the public health districts as well as a referral system for services outside the scope of these agencies. The vision is to have a single enrollment form and navigator type position to help clients access services for which they are in need and for which they qualify. This is a large expansion from the MCH activities implemented within the past few years such as the immunization -- WIC linkage. As this model develops, a focus will be placed on a client-centered plan with specific goals including exit from public assistance. The target date to pilot the project is January 1, 2004.

/2005/ The Any Door Initiative has been piloted in one small office in health district 2 and is now being implemented district-wide. While the focus of this service integration project has been on the social services delivered through regional offices of the Department of Health and Welfare, coordination of service application and referral is occurring between the Department and the health districts. This will include common enrollment forms that will overlap to district delivered services such as WIC and CSHP and a navigation function that will assist clients in accessing public health services even though they are applying through a social service center.//2005//

/2005/ Idaho will be funding an obesity project this coming year with MCH funds from last year's grant. Not all funds were spent as planned because one time state funding was available to cover some of the MCH expenses. These funds will be administered by the WIC program and contracted to the district health departments. The health departments will provide training to physicians who care for children. The training will include: using body mass index (BMI) to identify children at risk for becoming overweight; importance of encouraging families to have meals together and engage in exercise (Bright Futures Materials); and to promote and support continuation of breastfeeding. An evaluation will be conducted by staff from the Immunization Program Quality Assurance Review Team to determine the use of BMI in physician offices. A follow-up will also be conducted among parents that volunteer to participate in the project to determine if they have changed their meal time habits and increased exercise.

Another project that is included in the FFY 05' budget proposal is a perinatal project. Currently, there is considerable anecdotal evidence indicating poor birth outcomes among births attended by non-certified midwives. This project will be two fold: first to gather data on birth outcomes of deliveries attended by lay midwives and to begin education efforts to ensure expecting parents

are aware of the benefits of working with qualified individuals to improve the opportunity to have healthy babies.

And the last new initiative is to fund a full-time research analyst located within the Division of Health's Bureau of Vital Statistics and Health Policy to work with MCH programs. The focus will be on developing and analyzing outcome measures for each of the MCH funded programs.//2005//

/2006/ Idaho is initiating a project to improve access to prenatal dental care, targeting low income women during their second trimester. This project will seek to achieve two goals, first is to increase referrals by obstetric providers, second to increase the number of pregnant women that actually receive dental services during pregnancy//2006//

/2010/ The prenatal dental care program was discontinued due to the difficulty of finding dentists willing to participate. //2010//

/2008/ During state fiscal year 2007, the breastfeeding coordinator in the WIC program completed a breastfeeding friendly workplace initiative. WIC staff worked with regional breastfeeding coalitions on effective means of working with employers to make simple changes that encourage continued breastfeeding. The coalitions were provided toolkits that they can then provide to employers. //2008//

Finally, as SFY 2001 drew to a close, the continuation of genetic laboratory and clinical services in Idaho by the Bureau of Laboratories, became problematic. With the retirement of the Genetics Program Coordinator and the loss of a trained cytotechnologist, we were faced with the problem of recruitment of experienced individuals. At the same time we encountered budget problems with the operation of the Bureau of Laboratories.

In the face of these circumstances, we attempted to evaluate the status and future of the Genetics Program. To assist us, we consulted on several occasions with one of our Board Certified Geneticist consultants and his associates. This came on the heels of indications that one or both of our local regional medical centers had an interest in establishing both genetic clinical and/or laboratory capability. Due to a lack of medical geneticists in the state, we explored the prospect of recruiting and sharing a trained individual with one or both hospitals. After those discussions, it became clear that any such opportunity was not likely to take place in the near future. As a result, a decision was made to reorganize the Genetics Program, leaving the laboratory activities in place at the Bureau of Laboratories and transferring the newborn screening and the genetics clinic activities to the Bureau of Clinical and Preventive Services, the Title V agency.

/2004/ The previous program manager for the Genetics and Newborn Screening Programs resigned this past spring. At that same time the Department has been requested to cut 117 positions. The Program Manager position remains vacant and we are uncertain at this time when we will be able to fill it. Anne Spencer, a Masters level genetics counselor, continues to serve as a point of triage for clinical services, providing specialty consultation to health care staff, compiling family history, reviewing medical records, assessing risk and providing counseling to individuals and families.

/2005/ Brett Harrell, Manager of the state CSHCN Program, is now responsible for managing genetics and newborn screening. This was a natural fit since many of the children served through the genetics program and those diagnosed through newborn screening fall within the federal definition of CSHCN.//2005//

/2007/ In 2007 Mitch Scoggins replaced Brett Harrell following Brett's Retirement. Mr. Scoggins now manages the CSHCN, Newborn Screening and Genetics Programs. //2007//

/2009/ In 2008 the Children's Special Health Program hired Carol Christiansen, RN to support the Newborn Screening and CSHCN Programs. //2009//

/2010/ As the newborn screening program systems have been improved and the in-service trainings at hospitals are ongoing, CSHP's new RN has been branching out to different areas. Carol has also been preparing materials for teaching Transition to Adulthood classes for CSHCNs. In early 2009 Carol test-flew her curriculum at the Tools For Life Conference in northern Idaho. //2010//

/2004/ Another significant change in the area of genetics coming in September 2003 will be a new pediatric endocrinologist at St. Luke's Hospital in Boise Idaho. This will greatly reduce the current backlog of patients seen at the Department's genetics clinics and provide opportunities for the program to focus on education activities. And lastly, as a result of a General Fund reduction, the state Newborn Screening Program was required to change their rules. The new rules, which were approved by the 2003 legislature, include a fee for service structure and mandates screening for 5 metabolic conditions. Idaho currently tests for over 24 conditions via tandem mass spectrometry at the state contract lab, Oregon Public Health Laboratory.

/2005/ Dr. Alex Karmazin, Pediatric Endocrinologist, is on staff with St. Luke's Regional Medical Center as planned and all endocrinology patients previously served by state staff will be transitioned to Dr. Karmazin by October 1, 2004. All new patients are referred direct.

The Newborn Screening Program recently expanded newborn screening testing to include hemoglobin disorders and Congenital Adrenal Hyperplasia.//2005//

/2009/ The Newborn Screening Program has expanded to include Cystic Fibrosis testing.//2009//

Current MCH Priorities

A reexamination of health priority areas was conducted in May 2001, using an abbreviated needs assessment process. Division of Health and District Health Department representatives reviewed health status data and current program expenditures. Program staff provided summaries and proposals for continued and new activities.

Issues were prioritized based upon these criteria: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amenable to intervention/intervention proven effective by research. This process reaffirmed Idaho's areas of need identified in the five-year needs assessment and focused MCH activities during FY 2002 to impact these issues. The ten areas identified are:

Infant mortality and low birth weight
Adolescent pregnancy
Vaccine preventable diseases
Injuries
Substance and physical abuse
Investigation and control of "clusters" of reportable diseases and conditions
Prenatal care utilization
Children's access to health care coverage
Risky behavior in adolescents
Increased data capacity

/2009/ A number of factors have greatly influenced Idaho's MCH Title V program and the state priorities that were identified in the 2006 application. Below is a list of state priority areas that currently reflect the need of Idaho's MCH population. These are not in priority order; they are presented as a list of 7 key areas needing attention.

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.
2. Public Health will work with Medicaid to explore options to maximize services to the MCH population.
3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.
4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2 years of age.
5. Work with Medicaid, the newly formed Division of Behavioral Health and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.
6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.
7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy. //2009//

An attachment is included in this section.

B. Agency Capacity

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Ryan White CARE Act, Title II), immunization, WIC, programs for children with special health care needs, the SSDI position and grant, and most recently the newborn metabolic screening program and genetics clinics. The chief of BOCAPS provides additional fiscal oversight and program review for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services, Bureau of Health Promotion, Bureau of Health Policy and Vital Statistics and Division of Family and Community Services are included with this submission (Figures 4, 5, 6, 7, 8 and 9). /2006/ Bureau of Health Promotion is now the Bureau of Community and Environmental Health. //2006//

/2005/ Two new programs were added to the Bureau of Clinical and Preventive Services; Worker Health and Safety and Women's Health Check. Worker Health and Safety is a program focused on reducing injuries to Department of Health and Welfare employees and does some consultation to the general public. Women's Health Check is the Idaho Breast and Cervical Cancer Screening Program. Also, the Bureau of Health Promotion is now called the Bureau of Community and Environmental Health.//2005//

/2006/ A new program was added to the Bureau of Clinical and Preventive Services to support the Division of Health's information technology programs including WIC's data base, the Immunization Registry, Health Alert Network, and the National Electronic Disease Surveillance System. This program's primary function is a help desk and to also assist with managing system upgrades and maintenance. //2006//

/2007/ With the resignation of the Health Systems Support program manager in February 2006, and the retirement of one of the employees in April, the management of the IT help desk staff was placed back in the programs, WIC, Immunizations and Office of Epidemiology and Food Protection. //2007//

/2003/ Responsibilities for the Child Mortality Team have been transferred to the Bureau of Emergency Medical Services during state fiscal year 2002.

/2007/ The Child Mortality Review Team was disbanded in 2003. Idaho is aggressively overhauling the EMS patient care reporting system and implementing a trauma registry for hospitals to report on severely injured patients to counter pose against mortality data. The published reports of the CMRT showed that injury was the prevailing issue. //2007//

/2004/ As of January 2003 epidemiology services are now provided through the Office of Epidemiology and SSDI operates out of the Bureau of Health Policy and Vital Statistics.

/2004/ In an effort to coordinate MCH programs divided among the various offices, bureaus and divisions, quarterly meetings are held among all MCH funded programs as well as others such as WIC and substance abuse who are directly involved with providing services to the MCH population. Each meeting has a set agenda established by the MCH director with input from meeting participants. Based on comments provided during last year's review, the meeting functions have changed. They still include information sharing, but added to each meeting are planning discussions. For example, during our most recent meeting, a discussion was facilitated by the Asthma program manager to determine how multiple MCH programs can work together to most efficiently serve our clients. Another phase of the discussion included planning for addressing obesity among the MCH population. Input was gathered from the meeting participants and an action plan will be developed among the specific programs targeted to initiate this collaborative effort.

/2007/ Due to waning attendance, the quarterly MCH meetings were disbanded in 2005. We are trying a new approach of monthly meetings with the Bureau Chiefs of Clinical and Preventive Services, Community and Environmental Health and a representative from the Division of Medicaid. This planning should identify and support opportunities for program integration and enhancement. Others will be brought to the table as is appropriate. //2007//

/2008/ The Medicaid representative with whom we were regularly meeting resigned and the position was not refilled. There is not currently an individual at Medicaid who functions in a broad capacity and is capable of addressing a wide range of issues. The Bureau Chiefs of Clinical and Preventive Services (MCH Director) and Community and Environmental Health meet regularly and contact personnel from other Divisions as necessary. //2008//

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." He/she serves on the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2010 (HP) objectives for the nation.

Bureau of Clinical and Preventive Services (BOCAPS)

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. That portion of the Bureau's mission, related to maternal and child health, fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

Newborn Screening Program

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." The current newborn test battery includes screening for congenital hypothyroidism, galactosemia, maple syrup urine disease (MSUD), and biotinidase deficiency, in addition to PKU.

/2003/ The 2002 Legislature discontinued state fiscal support for the Idaho Newborn Screening Program with the start of state fiscal year 2003. With support from community organizations, such as the Idaho Medical Association, the Idaho Hospital Association, the Idaho Perinatal Project, and the Idaho Chapter of the American Academy of Pediatrics, Division of Health leadership instituted a fee for the Newborn Screening Program, effective July 1, 2002.

/2004/ This new fee structure was approved by the 2003 State Legislature. The impact of this new structure has been to increase the number of conditions diagnosed through the program. Since Oregon Public Health Lab has been providing screening services and physician consultation for decades, this change was transparent at the provider level other than the new fee structure. We continue to see a high rate of testing among our infant population with less than two percent not being tested, opting out for religious or personal reasons.

/2005/ Two new tests were added to the newborn screening program this past year. They include hemoglobinopathies and Congenital Adrenal Hyperplasia.//2005//

/2007/ Cystic fibrosis will be added to the newborn screening program in the fall of 2006. //2007//

/2009/ CF was added to newborn screening testing in July of 2007. Idaho's NBS panel now exceeds the recommendations of the March of Dimes.//2009//

Children's Special Health Program.

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

/2005/ The CSHP program manager is now administratively responsible for overseeing the state newborn screening and genetics programs.//2005//

/2006/ CSHP rules were revised during the 2005 legislative session. The most significant change was to change eligibility criteria. Previously the program was open to children meeting certain diagnostic criteria regardless of insurance status. The rules have been revised to limit program services to uninsured children only. //2006//

/2010/ CSHP Rules were revised during the 2009 legislative session to allow CSHP to provide medical foods in addition to medical formula for children with Phenylketonuria. This new provision will be implemented on July 1, 2009. //2010//

The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

/2003/ Roger Perotto retired as of August 2001. Russell Duke, M.S., became the Chief of the Bureau of Clinical and Preventive Services in June of 2002. He was Acting Chief of the Bureau of Clinical and Preventive Services from December 2001 through his permanent appointment. His prior position was Chief, Bureau of Environmental Health and Safety.

/2007/ Russell Duke, M.S., resigned as Bureau Chief of the Bureau of Clinical and Preventive Services in October 2006. In December 2006, Ms. Dieuwke A. Spencer, R.N., M.H.S. was hired as Bureau Chief. Prior to this position, Ms. Spencer was the Section Manager for Chronic Disease in the Bureau of Community and Environmental Health for a year and previously the Supervisor for the Office of Epidemiology and Surveillance at Central District Health Department

in Boise, Idaho where she had been employed for 14 years. //2007//

Susan E. Ault, B.S.N., R.N., A.R.N.P., has been the Family Planning Program Manager since 1988. This program has been re-named the Reproductive Health Program. Ms. Ault has also served as a provider of family planning services, school nurse and public health nurse for thirteen years prior to her appointment within the Bureau.

/2006/ Susan Ault has resigned her position and will be working with the Idaho Primary care Association. Her position is presently open for new applicants.//2006//

/2007/ Anne Williamson retired in December 2005 as the STD/HIV Program Manager. Jesus Sandoval, M.S.W. was hired in April 2006 as the Reproductive Health Program Manager. Mr. Sandoval has administrative oversight of the Title X program as well as the STD/AIDS program. //2007//

/2008/ Mr. Sandoval left the Department in October of 2006. In January 2007 Ms. Kathy Cohen, MS, was hired as the program manager for the Sexual and Reproductive Health Program. She has administrative oversight of the Title X program as well as the STD/AIDS program. //2008//

Christine Hahn, M.D., has been the State Epidemiologist since February 1997. Dr. Hahn is funded 0.5 FTE through the MCH Block Grant. She provides epidemiological support and consultation to all Title V programs and currently provides staff leadership to the Child Mortality Review Team.

/2004/ Dr. Hahn continues to provide consultation to all Title V programs in combination with the Deputy State Epidemiologist, Leslie Tengelsen. While support levels remain the same, funding is actually going to .3 of Dr. Tengelsen's salary and no support of Dr. Hahn's salary.

Leslie Tengelsen, Ph.D., D.V.M., has been the Assistant State Epidemiologist since 1998. She also provides epidemiological support and is currently involved in providing data analysis for the Bureau of EMS in assessing emergency response capability for pediatric patients as part of an MCH EMSC grant.

/2007/ Dr. Tengelsen's support levels remain the same, funding is at 0.5 of her salary. //2007//

/2003/ Drs. Hahn and Tengelsen are in the newly created Office of Epidemiology and are not a part of the Bureau of Clinical and Preventive Services.

/2005/ Jared Bartschi, Health Program Specialist in the Office of Epidemiology and Food Protection, is responsible for HIV/AIDS and STD surveillance and epidemiology, and other projects as assigned.//2005//

/2007/ Mr. Bartschi is funded at 0.25 FTE through the MCH block grant. //2007//

/2007/ Meredith Duran, Technical Records Specialist with the Office of Epidemiology and Food Protection, is funded 0.25 FTE through the MCH block grant. Ms. Duran provides support for the e-HARS computer system. //2007//

/2008/ Meredith Duran has moved to a Technical Records Specialist position with the Sexual and Reproductive Health Program. The position in the Office of Epidemiology and Food Protection is currently vacant and being recruited. //2008//

/2010/ Rhonda Jones is the Technical Records Specialist 2, Office of Epidemiology and Food Protection, working with Mr. Bartschi and providing support for e-HARS. Ms. Jones began working in her position in September 2007 and is funded with 0.25 FTE through the MCH block grant.//2010//

/2005/ Brett Harrell, B.S.W., M.A.T., was appointed Manager, Children's Special Health Program, in May 1995, after serving as the Director of Special Projects since November 1994. He was also given managerial responsibility for the newborn screening and genetics programs in the fall of 2004. Mr. Harrell has more than twenty years of experience in administration and management, which has included directing a regional hospice organization and a statewide diabetes association.//2005//

/2008/ Brett Harrell retired in December 2006. Mr. Mitch Scoggins, MPH assumed the position of CSHP Manager on May 7, 2007. Mitch has extensive international health experience where he has gained valuable experience in systems change and development. Judy Watson, RN who worked 10 hours per week with the newborn screening program also retired in December 2006. This part-time position has not been refilled. //2008//

/2009/ On the 21st of April 2008 Carol Christiansen joined CSHP in the role of Nurse, Registered Senior. Ms. Christiansen comes to Idaho with 14 years of experience in Florida's Children's Medical Services program, and is well qualified to bring clinical and programmatic expertise to CSHP. //2009//

/2003/Judy Peterson, M.S., R.D., L.D., provides nutrition consultation to the Children's Special Health Program for PKU clients as well as other nutrition related issues. She also works with the Idaho WIC Program. //2003//

/2004/ Judy Peterson, resigned in July of 2002, but continues to provide nutrition consultation to CSHP for PKU clients through her part time employment with St. Luke's Regional Medical center, a contractor of CSHP. Her position in WIC was refilled, but has not yet been used for PKU consultation. This may take place during the course of the coming year.

Emily Geary, M.S., R.D., L.D., has worked as the Nutrition Education Coordinator for the Idaho WIC Program since 1998. Ms. Geary serves as a consultant for metabolic conditions impacted by nutrition, for obesity initiatives, and began providing consultation to CSHP in 2004 for children with PKU and other metabolic conditions. //2004//

/2006/ Emily Geary transferred from the WIC program to the Breast and Cervical Cancer Screening Program. Jean Heinz was hired in her place. Ms. Heinz has over 20 years of experience as a Registered Dietitian and most recently worked for the Idaho State Department of Education, Child Nutrition Programs.//2006//

/2007/ In January, 2005, Katie Bagley, RD, LD, was hired in a part-time position to provide dietary and nutritional information to Idaho PKU patients and families. Katie's first several months in the position resulted in quantifiable increases in formula usage by patients, greater patient compliance with monthly phe level blood tests, and positive feedback from families concerning her involvement with and commitment to the health and wellbeing of their children. //2007//

/2010/ The Children's Special Health Program has contracted with a dietitian firm to provide support to the state's PKU program. This contract took over the duties of Katie Bagley, who no longer is with us. A pediatrician has also been contracted to do short-term follow up on Idaho's infants who screen as potentially positive for cystic fibrosis.//2010//

Linda Morton, M.P.H., R.D., L.D., I.B.C.L.C., has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 1993. Ms. Morton has over 20 years of varied work experiences in public health and is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.

/2005/ Linda Morton is working with the Department's Any Door Initiative and Cristi Litzsinger,

R.D., L.D., I.B.C.L.C., is serving as the State Breastfeeding Promotion and Outreach Coordinator for the WIC Program. Cristi has 7 years of experience working as a WIC Nutritionist.//2005//

/2008/ Cristi Litzsinger is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.//2008//

/2006/ Linda Morton has resigned from the Department of Health and Welfare. Cristi Litzsinger was hired in her place. Ms. Litzsinger has 8 years experience working in WIC and is an Internationally Board Certified Lactation Specialist.//2006//

Christina Giso, M.B.A., is Idaho's current MCH State Systems Manager (formerly designated the State Systems Development Initiative Coordinator) and the new Genetic Services Program Coordinator. Her advanced degree is in health systems administration, and her primary focus has been the MCH block grant needs assessment and performance and outcome measures. Currently, she serves as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

/2003/ Christina Giso is responsible for the Idaho Newborn Screening Program and the Genetic Services Program. She is no longer the AMCHP State Data Contact.

/2004/ Christina Giso resigned in April of 2003. The position is currently vacant and may not be filled pending Full Time Employee (FTE) reductions in the department. If the position is eliminated, the responsibilities will be transitioned to CSHP.

/2008/ The Immunization Program Manager resigned in February 2007. Ms. Rebecca Coyle, MS, assumed the position and started in April. Ms. Coyle most recently served as a CDC Public Health Advisor to the Minnesota Immunization Program. //2008//

/2008/ In March 2007 Traci Berreth, MCH Special Projects Coordinator accepted a Division level position. The Special Projects Coordinator was a 0.5 FTE temporary position that has not been refilled at this time. //2008//

Bureau of Health Promotion

/2005/ Name changed to the Bureau of Community and Environmental Health.//2005//

Ginger Franks, Dr.P.H., has been the Injury Prevention Program Manager since 1996. She was a public health microbiologist in the California system before coming to Idaho. Her program is focusing on motor vehicle safety and sexual assault prevention, collaborating with the Departments of Transportation and Law Enforcement.

/2005/ With the strengthening of Idaho's adult safety restraint law in July 2003, the program objective addressing adult safety restraints was dropped. In 2005 we will be working to move the child safety restraint program to state and local partners. State partners will include Idaho Transportation Department and AAA-Idaho.//2005//

/2003/ Ginger Floerchinger-Franks, Dr.P.H. Her program is focusing on motor vehicle safety, bicycle safety, pedestrian safety, and teen rape prevention, collaborating with the Department of Transportation. Additionally, Dr. Franks is the coordinator for the Preventive Health & Health Services Block Grant and the Principal Investigator for the Rape Prevention Education Grant.

/2005/ The (Unintentional) Injury Prevention Program is changing focus by beginning to work with the elderly population. Current objectives focus on developing a network of exercise classes working on prevention falls and transitioning the child car safety seat program to other partners.

Kaili McCray has taken the lead for the Sexual Violence Prevention Program and is acting as Unit Manager for the Injury and Violence Prevention Unit. Although Ginger remains Idaho's coordinator for the Preventive Health and Health Services Block Grant, Kaili is the Principal Investigator for the Rape Prevention Education Grant.//2005//

/2004/ Injury Prevention Program's role has enlarged to include elderly fall prevention and suicide prevention. Kaili McCray, Ph.D., has been hired as the Manager for the Rape Prevention Education Program and is the Principal Investigator for the Rape Prevention Education Grant.//2004//

/2010/ Steve Manning is currently the Managr of the Injury Prevention and Surveillance Program located within the Bureau of Community and Environmental Health. Mr. McCray left this post in 2007. The Injury Prevention Program is currently looking at ways to improve pedestrian safety.//2010//

/2003/ Shelli Rambo-Roberson has replaced Angela Wickham as the Adolescent Pregnancy Program Manager. Shelli has a BS in Social Work and a BA in Education and has been the Adolescent Pregnancy Prevention Manager since last September. Her program is abstinence based and she works in collaboration with the seven health districts to offer community and school programs; the Idaho Governor's Council on Adolescent Pregnancy Prevention to provide a statewide media campaign; and other community programs to offer mini-grants that support youth asset building and pregnancy prevention at the local level.//

/2009/ Mercedes Munoz replaced Shelli Rambo-Roberson as the Adolescent Pregnancy Prevention Program Manager. The program has moved from the Governor's Office to the Bureau of Community and Environmental Health. //2009//

/2006/The Adolescent Pregnancy Program has been transferred to the Governor's Office.//2006//

Lisa Penny, B.S., R.D.H., has been Oral Health Program Coordinator since 1987. Ms. Penny has served within the Bureau since 1970, conducting school and migrant programs throughout the districts for seven years, and later directing educational and training activities as the state Dental Health Education Consultant. Ms. Penny has established a statewide program to promote oral health, increase use of preventive dental health measures, and improve access to dental care.

/2008/ Lisa Penny retired in March 2007 after 37 years with the Oral Health Program. Interviews for the Oral Health Program Manager position were conducted in May 2007. //2008//

/2009/ Debra James, R.D.H. was hired as the Oral Health Program Manager in 2007. She has since resigned, and efforts are underway to refill the position which is vacant at this time. //2009//

/2010/ The Oral Health Program Manager position proved to be extremely difficult to fill. We were unable to recruit a dental hygienist to the position. Mimi Hartman-Cunningham, MA, RD, CDE, is now managing both the Diabetes Program and the Oral Health Program. Both of these programs are located in the Bureau of Community and Environmental Health. //2010//

/2010/ Mimi Hartman-Cunningham is the Program Manager of the Oral Health Program. She also has a dual role as Program Manager of the Diabetes Prevention and Control Program. //2010//

/2008/ The Adolescent Pregnancy Program will be transferred from the Governor's Office back to the Bureau of Community and Environmental Health in July 2007. //2008

Office of Rural Health and Primary Care

Andrea Fletcher, M.P.H, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.

/2005/ Mary Sheridan, RN, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.//2005//

Laura Rowen, M.P.H., is the Primary Care Office Manager. Her role is to assess the state for areas of medical under service, barriers in access to health care, and identification of health disparities.

/2009/ In November 2007, the Division of Health created a new bureau by uniting the Health Preparedness Program and the Office of Rural Health and Primary Care into the Bureau of Health Planning and Resource Development. Both programs are health systems focused, working closely with hospitals, federally qualified health centers, emergency medical service providers, local district health departments, associations, universities and other key players in the health system. By joining forces into this new bureau, it better integrates complementary activities, avoids program duplication and helps share vital resources, increasing the Division of Health's overall capacity for planning and supporting sustainability of health systems. Angela Wickham, M.P.A., a nine year employee of the Department of Health and Welfare, is the bureau chief.

Bureau of Health Policy and Vital Statistics

/2008/ The Bureau Chief, Jane S. Smith, was named acting Division of Public Health Administrator in June 2006. Mrs. Smith was appointed to the Administrator position in December of 2006. James Aydelotte assumed the position of Chief, Bureau of Health Policy and Vital Statistics in February 2007. Mr. Aydelotte has been with the Bureau for ten years. //2008//

Dianna Willis, M.A., has been the Perinatal Research Analyst (a.k.a. Senior Research Analyst) since 1998. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She was instrumental in conducting the Pregnancy Risk Assessment Tracking System (PRATS), and will be involved in conducting future surveys. Additionally, she has analyzed women's access to and utilization of prenatal care in Idaho, using Geographic Information Systems (GIS) technology. She has served as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP) and will soon be the MCH State Systems Manager.

/2003/ Dianna Willis is the current SSDI Program Manager for Idaho.

/2004/ Dianna Willis also serves as the State Data contract for the Association of Maternal and Child Health Program (AMCHP) and on the Advisory Board for the Idaho Perinatal Project.

/2006/ Dianna Willis recently resigned and the position is currently open for new applicants. //2006//

/2007/ Teneale Chapton, M.S., has been the Perinatal Research Analyst (a.k.a. Principal Research Analyst) since July 2005. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Teneale Chapton is the current SSDI Program Manager for Idaho as well as a member of the Association of Maternal and Child Health Programs (AMCHP) and serves on the Advisory Board for the Idaho Perinatal Project. //2007//

/2009/ Teneale Chapton, M.S. accepted the position of coordinator for the immunization registry (IRIS). Jacqueline Daniel is now the research analyst responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Jacqueline is the current SSDI Program Manager for Idaho and serves on the Advisory Board for the Idaho Perinatal Project. //2007//

/2004/ Cory Reed is a Senior Research Analyst with a background in statistics and statistical computing that is working with MCH programs. Cory works with a variety of data sources to provide analytical support for MCH related activities including WIC, family planning services, and infertility prevention. Cory also has several years' experience using public health survey data including the Behavioral Risk Factor Surveillance System to analyze risk factors, chronic disease prevalence, and access to care issues that affect women's health.

/2005/ Cory Reed resigned and Greg Seganos has been hired in his place. Mr. Reed worked half time for MCH. Mr. Seganos works full time for MCH. //2005//

/2008/ Mr. Greg Seganos resigned in October 2007. In February 2007 Mr. Ward Ballard assumed the position of MCH research analyst. This continues to be a full time position. //2008//

Division of Family and Community Services

Patricia Williams, is the Idaho CareLine Community Resource Coordinator for our toll-free referral service.

/2007/ Patricia Williams is the Idaho CareLine Program Supervisor. //2007//

/2009/ Patricia Williams retired. Nina Dillon is the Idaho CareLine Supervisor. //2009//

/2010/ MCH statistics, surveillance data and special reports can be accessed through the following web site: http://healthandwelfare.idaho.gov/Health/HealthStatistics/tabid/102/default.aspx //2010//

Public Health Districts

District health departments, who carry out implementation of state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, dental hygiene, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the master's level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, selected materials/supplies and funding for special projects. The main funding streams that complement Title V are county funds, fees, the State General Fund, Title X, Preventive Health and Health Services Block Grant, CDC's Immunization, HIV/AIDS Programs and the WIC Program.

C. Organizational Structure

Statewide service delivery for the state agency is carried out by the public health districts and other non-profit and community based organizations through written contracts between the state and the agencies and organizations. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A description of the state agency programs and their capacity to provide services for each population group

follows.

Pregnant Women, Mothers and Infants

The Reproductive Health Program (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women and infants and children through age 4 with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the program maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System.

The Newborn Screening and Genetics Services Program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. Additionally, clinic activities are provided through contracts with board certified medical geneticists for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing, available through the Idaho Bureau of Laboratories, and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided through these contractors to Idaho physicians and other health care professionals involved with all segments of the MCH population.

/2004/ Genetic testing is no longer available through the Bureau of Laboratories but is available through a St. Luke's/St. Alphonsus genetics lab.

/2005/ Pediatric Endocrinology clinics will discontinue effective September 30,2004. Since September of 2003 patients have been transitioned to a new pediatric endocrinologist practicing at St. Luke's Children's Hospital.//2005//

/2009/ The Genetics Program will be adding one clinic per month. This will be done through a pilot program with the Children's Specialty Center at St. Luke's Regional Medical Center. This pilot program will run through the fall of 2008 with the intent of moving all clinics out of the State Laboratory facility and to the Children's Specialty Center.

/2010/As of October 2008 all the Genetics clinics were contracted to the Children's Specialty Center at St. Luke's Regional Medical Center, though Idaho's CSHCN program continues to fund the clinics. In February of 2009, the Metabolic clinic (including PKU) was also contracted to the Children's Specialty Center. //2010//

Children

/2005/ Note: The Bureau of Health Promotion is now the Bureau of Community and Environmental Health. However, the Women's Health Check Program is now with the Bureau of Clinical and Preventive Services. The Women's Health Check Program works together with health care and insurance providers, survivors, and health educators to move forward in the fight against breast and cervical cancer in Idaho.//2005//

/2007/ The Bureau of Community and Environmental Health received funding for Comprehensive Cancer planning. //2007//

The Bureau of Health Promotion administers the Title V programs of Oral Health, Adolescent Abstinence Grant, and Injury Prevention. The non-Title V programs include several preventive health education programs: arthritis, diabetes and cancer control, i.e., tobacco prevention and breast and cervical cancer screening. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

The Oral Health Program contracts with the district health departments to perform surveys of oral health status, as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects, and school sealant projects.

The Abstinence Education Block Grant is administered from this bureau. Presently, the program has contracted with the public health districts to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that address adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Idaho Governor's Council on Adolescent Pregnancy Prevention, which is staffed by the bureau.

/2007/ Adolescent Pregnancy Prevention has been transferred to the Governor's Office.//2007//

/2008/ Adolescent Pregnancy Prevention will be transitioning from the Governor's Office back to the Department of Health and Welfare, Bureau of Community and Environmental Health, in July 2007.//2008//

The Injury Prevention Program provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

/2003/ The Injury Prevention Program works with state and local partners to provide health promotion campaigns and activities for universal use of motor vehicle safety restraints, bicycle safety, and pedestrian safety. Through the Rape Prevention Education Grant the program also addresses teen rape prevention.

/2005/ The Injury and Violence Prevention Unit work with state and local partners to develop and implement programs addressing child motor vehicle safety restraints, fall prevention for community-dwelling seniors aged 65 years and older, and rape and sexual assault prevention on college campuses.//2005//

/2004/ The Injury Prevention Program continues to provide child safety seats and installation education with MCH funds. Also, in April 2003, the Injury Prevention Program began working with the DHW Division of Family and Community Services, Mental Health Program, the Idaho Department of Education, and community groups (SPAN-Idaho based out of Boise State University) to develop a comprehensive statewide suicide prevention plan.

/2005/ The Injury Prevention program is working to transition the child safety seat distribution and installation education to state and community partners.//2005//

/2007/ The Injury Prevention Program has transitioned successfully child safety seat distribution and installation and education to state and community partners. The program is currently focusing on fall prevention for the elderly. //2007//

/2009/ During the coming year, we will be exploring means to improve Idaho's Injury Prevention Program. This will include looking at the Poison Control program and all aspects of childhood injury. This has been an issue with Idaho's Block Grant Reviews for a number of years. We plan

to be well positioned to address this in our 2010 application and 5 year needs assessment. //2009//

/2010/ During this year, we have been working to expand the Injury Prevention & Surveillance Program and are exploring potential sources of sustainable program funding. Emphasis is now being placed on childhood injury prevention, especially with respect to poisoning prevention, improvement of pedestrian and cycling safety in Idaho communities, and aquatic recreation safety. With this new program emphasis, we should be well positioned to address childhood injury prevention in our forthcoming 2010 application and 5 year needs assessment. //2010//

Children with Special Health Care Needs.

The Children's Special Health Program (CSHP) provides and promotes direct health care services in the form of family centered, community-based, coordinated care for children with special health care needs, including phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories including, neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

/2005/ In addition to CSHP, the program manager is responsible for newborn screening and genetics.//2005//

/2010/ CSHP also manages two adult programs, Adult PKU and Adult Cystic Fibrosis./2010//

All MCH Populations

The State Epidemiologist provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. Additionally, the Deputy State Epidemiologist is engaged in providing data analysis and consultation to the Bureau of EMS to improve emergency response capabilities for pediatric patients. The EMS effort is being funded by an MCHB EMSC grant.

/2007/ The State Epidemiologist and the Deputy State Epidemiologist provide health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population.//2007//

/2009/ Robert Graff, Ph.D., a chronic disease epidemiologist, was hired by the Office of Epidemiology and Food Protection. //2009//

The STD/AIDS Program provides HIV prevention education activities as well as counseling and testing. It also distributes HIV/AIDS therapeutic drugs to eligible clients.

/2007/ Jared Bartschi oversees contractual performance of the district health departments related to STD and HIV investigations and performs analysis of epidemiologic data. Merideth Duran is involved with the different aspects of data management, including activities to assure data quality and data entry.//2007//

/2008/ Merideth Duran joined the Sexual and Reproductive Program in May 2007. The interviewing process has begun for Merideth's replacement in the Office of Epidemiology and Food Protection.//2008//

/2010/ Rhonda Jones, Technical Records Specialist 2, was hired in September 2007 to

fulfill the role vacated by Ms. Duran. Rhonda supports e-HANS and works closely with Mr. Bartschi on data management and data entry. //2010//

The toll-free telephone referral service, Idaho CareLine, provides information and referral service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

/2006/ The Idaho CareLine has been designated the 211 Call Center for Idaho. Callers can now access referrals for any health and human service issue by dialing 211 or 1-800-926-2588.//2006//

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducted a Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

/2003/ Beginning with the federal fiscal year 2002 MCH Block Grant, the Perinatal Data Analyst assumed responsibility for the State Systems Development Initiative (SSDI) Grant.

/2004/ The Perinatal Research Analyst will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP) and will serve on the Advisory Board for the Idaho Perinatal Project.

The Office of Rural Health and Primary Care is focused on improving services in rural and underserved areas.

/2009/ In November 2007, the Division of Health created a new bureau by uniting the Health Preparedness Program and the Office of Rural Health and Primary Care into the Bureau of Health Planning and Resource Development. Both programs are health systems focused, working closely with hospitals, federally qualified health centers, emergency medical service providers, local district health departments, associations, universities and other key players in the health system. By joining forces into this new bureau, it better integrates complementary activities, avoids program duplication and helps share vital resources, increasing the Division of Health's overall capacity for planning and supporting sustainability of health systems. //2009//

D. Other MCH Capacity

All state level MCH funded personnel (with the exception of the genetics clinical personnel and the Child Mortality Review Team Coordinator (CMRT)) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Health Policy and Vital Statistics are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. Genetics clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the Bureau of Laboratories located on a separate state campus approximately three miles from the primary office building. The CMRT Coordinator's office is less than one block from central office. Distance does not deter joint collaboration, which occurs via periodic meetings, telephone, electronic mail, and FAX communication.

A 1.0 FTE Program Manager, a 1.0 FTE Special Projects Director, and 1.0 FTE clerical specialist staff the CSHP program. In addition, services for PKU and high-risk children not covered by other service providers (WIC or EPSDT) are coordinated through CSHP. A Nutrition Specialist provides 0.4 FTE technical support to CSHP to assure PKU and special nutritional needs are met.

/2009/ The CSHP Special Projects Director position has been reclassified to a Registered Nurse, Senior position. The position remains 1.0 FTE. //2009//

/2006/ The CSHP Manager is responsible for the management aspects of the genetics program as well as for newborn screening. A full time administrative assistant and part-time genetics counselor coordinate genetic clinics, counseling, diagnosis and follow-up care to women, infants and children.//2006//

/2004/ The Newborn Screening and Genetics Program Manager resigned this past Spring. Plans to fill the position or transfer program responsibilities to CSHP are pending the decision on whether or not the agency will maintain the FTE.

A 1.0 FTE program coordinator and a 0.5 FTE secretary staff the Oral Health Program.

The 1.0 FTE MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Health Policy and Vital Statistics.

The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 4.0 FTE Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

/2006/ The CareLine is now supported by a 1.0 FTE Community Services Coordinator and 6.5 FTE Customer Service Representatives.//2006//

/2007/ The CareLine is supported by a 1.0 FTE Program Supervisor and 9.0 FTE Customer Service Representatives.//2007//

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health, Epidemiology, Immunization, Reproductive Health, and Genetics Services. Within the Bureau of Health Promotion programs receiving MCH Block Grant funds are: Injury Prevention and Oral Health Promotion. The Health Statistics section of the Bureau of Health Policy and Vital Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Council for the Deaf and Hard of Hearing receives funding via a contract with the Title V Agency, and the Idaho CareLine receives direct MCH block grant funding.

/2003/ The Office of Epidemiology was created in 2001 and reports directly to the Administrator of the Division of Health.

/2004/ The Immunization Program no longer receives block grant funds. The Bureau of Emergency Medical Services receives funds for the part time CMRT Coordinator position.

/2008/ Idaho lost TANF funding that was being used to support outreach and education efforts in the Immunization Program. The Division of Health is in discussions with the seven health districts to shift MCH funds within the Bureau of Clinical and Preventive Services programs in order to cover this shortfall. //2008//

/2009/ Title V funds have supported the Immunization Program during the past year. //2009//

/2006/ The child mortality team has been disbanded. //2006//

There are a number of other programs within the Department of Health and Welfare that are tied in varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Health Promotion receives MCH funds via the Abstinence Grant. This has also been true of the Bureau of Emergency Medical Services which has received an MCH grant for children's injury surveillance. Also, the Health Statistics Program of the Bureau of Health Policy and Vital Statistics is now administratively responsible for the SSDI grant.

/2005/ Idaho's breastfeeding promotion and support initiatives receive MCH funds periodically.//2005//

In addition to having funding ties to MCH programs there are a number of other programs with the umbrella Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the STD/AIDS program; within the Bureau of Health Promotion: the Breast and Cervical Cancer Early Detection program, the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention programs; within the Bureau of Health Policy and Vital Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, and the Infant Toddler program.

/2005/ Breast and Cervical Cancer Early Detection program is now within the Bureau of Clinical and Preventive Services and known as the Women's Health Check Program.//2005//

/2006/ The Adolescent Pregnancy Prevention program is now with the Office of the Governor.//2006//

/2008/ In July of 2007, Adolescent Pregnancy Prevention will be transferred from the Governor's Office to Department of Health and Welfare, Bureau of Community and Environmental Health.//2008//

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This agency provides much of the important data used in program assessment including providing data on health insurance as well as that which defines access to care issues. Also, each of the seven District Health Departments have very strong ties to each MCH program through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

E. State Agency Coordination

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

Formal agreements exist between the Divisions of Health, Family and Community Services, and Medicaid. These agreements refer to relationships of the three divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, Early Intervention Services through the Infant Toddler Program, Special Education Services under the Individuals with Disabilities Education Act, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V (Maternal and Child Health Block Grant) Program, the Title X (Family Planning) Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating MCH prevention activities into the Medicaid Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

/2004/ During FY 2002, the MCH Oral Health Program, Medicaid, and the districts worked together to obtain provider status to allow reimbursement for preventive dental services provided by dental hygienists employed by the districts.

/2005/ During FY 2003, the MCH Oral Health Program and Medicaid engaged in ongoing discussions regarding early childhood caries prevention and the potential for integrating oral health with primary medical care through the Healthy Connections managed care program. Idaho Medicaid will reimburse physicians, physician's assistants and nurse practitioners for fluoride varnish application for children age 21 and younger. //2005//

/2006/During FY 2004, legislation changing the Idaho State Dental Practice Act was enacted, creating an extended access endorsement for dental hygienists allowing preventive dental hygiene services to be provided under general supervision in public health settings and allowing retired dentists to provide clinical dental services on a volunteer basis in non-profit dental clinics. Medicaid analyzed the potential cost impact if direct reimbursement were allowed to extended access endorsed dental hygienists. Currently, only district health departments or other entities that employ a dental hygienist can receive Medicaid reimbursement./2006/

/2007/During FY 2005, Idaho was one of 13 states selected to send a team to the CHCS Purchasing Institute Best Practices for Oral Health Access, held in Philadelphia in September 2005. The MCH Oral Health Program worked with the Division of Medicaid to develop the Idaho application. Information gained at the CHCS Purchasing Institute was timely and useful in developing the oral health component of the proposed Idaho Medicaid Modernization, which emphasizes prevention and disease management.//2007//

/2006/ Women's Health Check cooperates with the Divisions of Medicaid and Welfare to provide treatment for women diagnosed with breast or cervical cancer.//2006//

/2010/ The Children's Special Health Program Coordinator is a member of a Medicaid working group looking at the feasibility of implementing the Family Opportunity Act Medicaid Buy-In for CSHCN's in Idaho. //2010//

As indicated in the FY 1996 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

A formal agreement between Title V and the Title X Family Planning Program is unnecessary. These two federal programs jointly fund the Reproductive Health Program. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

Cooperation between the Reproductive Health Program (Title V addressing teens) and the STD/AIDS Program regarding the Infertility Prevention Program is documented in a file letter. The letter verifies a formal contractual agreement with the districts and the Bureau of Laboratories to provide STD testing. Both of these programs reside within the Bureau.

/2007/ Both the Title X Reproductive Health Program and the STD/AIDS Program have been merged together to form the Sexual Health Program./2007/

/2010/ The Sexual Health Program changed their name to Family Planning, STD, and HIV Program to more fully communicate their office responsibilities and focus. This program is currently being managed by Kathy Cohen.//2010//

The Bureau of Clinical and Preventive Services enjoys a traditional as well as efficient collaboration with the Bureau of Health Promotion with the latter having once been an organizational component of the former. This bureau provides health promotion activities for injury prevention, adolescent pregnancy prevention, breast and cervical cancer prevention, tobacco prevention, oral health promotion, diabetes control, arthritis, and rape prevention. The Bureau of Health Promotion collaborates with the Title V agency to impact those performance measures dealing with suicide, adolescent pregnancy and protective sealants.

/2009/ Several years ago, the Bureau of Health Promotion was combined with the Bureau of Environmental Health to form the Bureau of Community and Environmental Health. //2009//

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated Idaho CareLine. This service is administered through the Division of Family and Community Services.

Interagency agreements are reviewed on a periodic basis, depending on the expiration date of an interagency agreement if there is one, and subject to the cooperative relationships that these cooperative agreements represent.

Councils, Coalitions, and Committees (State and Non-State Agencies)

In addition to the formal agreements mentioned above, the MCH program staff serve on many committees and advisory boards, including but not limited to:
a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Education Act (IDEA), Part C.
e) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
f) Healthy Child Community, an interdepartmental group interested in promoting the health and well being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.
g) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.
h) Idaho Breast and Cervical Cancer Alliance (IBCCA), dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring. ***/2010/ No longer in existence. //2010//***
i) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the

availability of state-of-the-art emergency medical care.
j) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
k) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children. /2005/ This group is no longer a functioning partnership. //2005//
l) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
m) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
n) Idaho Governor's Council on Adolescent Pregnancy Prevention. /2008/ Disbanded by the Governor.//2008//
o) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
p) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for date and acquaintance rape prevention.
q) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho with recommendations for preventing future child deaths. /2006/ This group is no longer active.//2006//
/2004/
r) Terry Reilly Health Service Dental Advisory Committee, which provides guidance for funding, volunteer networking and operation of the community health center dental clinics. /2006/ Committee no longer meets./2006/
s) Idaho Dental Hygienists' Association Community Outreach Committee, which seeks to expand access to oral health services through community projects and partnerships organized and/or conducted by the local component dental hygiene societies.
t) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
u) Action for Healthy Kids is a statewide initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity.
v) Healthy Weight Steering Committee is a diverse group with an interest in nutrition and physical activity. This group applied for and received funding from the Office of Women's Health, Region X, to conduct focus groups with postpartum women on issues related to weight and a statewide meeting on the issue of obesity in Idaho. /2007/ With the establishment of the Idaho Physical Activity and Nutrition Program, this committee no longer meets. Most participants now partner with the IPAN program.//2007//
w) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT Book and related efforts to track and promote the well-being of children in Idaho through research, education and mobilization strategies.
x) Friends of Children and Families Head Start Health Advisory Committee. /2006/
y) Association of State and Territorial Dental Directors Data Surveillance Committee. /2006/
/2009/
a) Early Childhood Coordinating Council
b) Developmental Disabilities Council
c) Idaho Immunization Congress -- a grassroots effort to start and establish a statewide immunization coalition
d) Early Years Conference //2009//

/2010/

a) Comprehensive Cancer Alliance for Idaho (CCAI) - a partnership between many individuals and organizations to address issues relating to the impact of cancer in Idaho. The CCAI is working to reduce the number of preventable cancers and decrease late stage diagnosis of treatable and survivable forms of cancer by improving screening rates in Idaho and to improve the quality of life of Idahoans impacted by cancer.
b) Operation Pink B.A.G. (Bridging the Access Gap) - A coalition of agencies and hospitals in Southwestern Idaho, funded through the Boise Affiliate of Susan G. Komen for the Cure, dedicated to increasing the Mammography rate for women over age 40, as Idaho is ranked 5oth in the nation. A website is now active with resources for the health care professional and hospitals. The project is expected to be expanded statewide within the next 2 years.
c) Breast and Cervical Cancer Medicaid Team - brings together 3 Divisions of IDHW to address unique issues relating to Women's Health Check clients who are diagnosed with breast or cervical cancer and transferred into the Medicaid system for the duration of cancer treatment.
d) Coordinated School Health Committee through Health and the Department of Education.
e) Healthy Tomorrows - Insurance coverage for children.
f) Idaho Parents Unlimited. (IPUL)
g) Canyon Area Coalition.
h) State and Territorial Injury Prevention Directors Association (STIPDA) - organization of professionals committed to strengthening the ability of state, territorial, and local health departments to reduce death and disability associated with injury and violence.
i) Idaho Safe Routes to School Advisory Committee - enable and encourage children to talk and bicycle to school; improve the safety of children walking and bicycling to school; and facilitate projects and activities that will reduce traffic, fuel consumption, and air pollution near schools.
j) Idaho Highway Safety Coalition -- reduce traffic deaths, injuries, and economic losses through outreach programs and activities that promote safe travel on Idaho's transportation systems.
k) Hispanic Partnership for Health. The main objective is to decrease health disparities experienced by Hispanics in Southwest Idaho.
l) The Tobacco Free Idaho Alliance (TFIA) meets quarterlyand is a statewide coalition.
m) The Asthma Coalition of Idaho also meets quarterly and is also a statewide coalition.
//2010//

Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: school health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

The Title V agency implements program strategies through contracts with the public health districts. Indeed, the core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Health administration and staff meet monthly with the Directors of the district health departments.

Federally Qualified Health Centers/Community Health Centers

The Office of Primary Care, formerly of the Bureau of Health Policy and Vital Statistics, has a cooperative agreement with the Idaho Primary Care Association to help expand access to primary care in Idaho. As the FQHCs and CHCs often represent the only health care available in

rural areas, past agreements have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer. Additionally, the Immunization Program maintains contracts with several FQHCs to provide immunization status assessments of their clinics as well as identifying barriers to immunization.

/2005/ The Reproductive Health program has an MOU in place with Family Health Services, a Community Health Center in Twin Falls, to pilot providing contraceptives to low income women in rural clinic sites. //2005//

/2006/ The MOU between Family Health Services and the Idaho Reproductive Health Program is currently in place until January 2006 when progress will be re-evaluated. Success of this partnership has been demonstrated by the 717 clients seen in CY04. In the first quarter of CY05, Family Health Services reported 421 clients have been seen in their clinics for reproductive health care. Eighty-two (82) percent of these clients reported incomes of less than 100 percent of the federal poverty level. An MOU is also in place between Southeastern District Health and Healthwest, a community health center, in Pocatello, Lava Hot Springs, and Downey, Idaho. Clinics in Lava Hots Springs and Downey serve an area with limited pharmaceutical services.//2006//

/2008/ The MOU's with community health clinics has been discontinued since the clinics can access 340(b) pricing directly.//2008//

Universities

The Division maintains a relationship with all three of Idaho's universities. Past projects have included a survey of high-risk populations for the HIV/AIDS Program by the University of Idaho and a survey of medical providers for the Office of Primary Care by Boise State University. The State Epidemiologist collaborated with Idaho State University on a CDC grant to study efficacy of the pertussis vaccine in outbreaks in Idaho. That university has also been a contractor with the Immunization Program to conduct assessments of the immunization status of patients seen in physician offices throughout the state. In 1999, the Title V agency collaborated with the Institute of Rural Health Studies (IRHS) at Idaho State University to develop a grant application to impact on alcohol use in pregnancy. During FY 2000, the University of Idaho was under contract to provide services related to the newborn hearing screening consortium. Currently, the Immunization Program is contracting with Boise State University and Idaho State University to provide student interns to private immunization providers to assist with the implementation of patient reminder/recall systems for their immunization patients.

/2005/ The Immunization Program no longer contracts with these universities as this program is already implemented.//2005//

F. Health Systems Capacity Indicators

Introduction

/2010/ While Idaho has some challenges and limitations in acquiring health data, i.e. no hospital discharge data, we have well established partnerships with both public and private stakeholders. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	28.0	20.0	18.3	16.0	17.0
Numerator	153	111	100	91	100
Denominator	54629	55482	54564	56950	58730
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data reflects Medicaid and Idaho CHIP enrollees only. General hospitalization data not available.

Notes - 2007
Data reflects Medicaid and Idaho CHIP enrollees only. General hospitalization data not available.

Notes - 2006
Data reflects Medicaid and Idaho CHIP enrollees only. General hospitalization data not available.

Narrative:
Idaho does not have hospital discharge data available, so we do not know the discharge rate for children or adults.

In an attempt to address the known contributors to hospitalizations among children (lack of knowledge among care providers, lack of access to medications during school hours, environmental triggers, and in-appropriate diagnosis and treatment), the Idaho Respiratory Health Program (formerly known as the Idaho Asthma Prevention and Control Program) and its partners, Asthma Coalition of Idaho, American Lung Association, Indoor Air Program, Idaho Department of Education, and School Nurses Organization of Idaho, are working with schools to increase awareness among and efficacy of school staff and has developed the School Asthma Management Model for Idaho (SAMMI) that was distributed to all schools in Idaho. SAMMI is an administrative, policy, and educational tool. SAMMI will be evaluated and updated by August 2009, and a tool similar to SAMMI will be designed for and distributed to childcare facilities and preschools. The Respiratory Health Program and its partners successfully passed legislation to allow children to carry their asthma inhalers and self-medicate while at school. The Respiratory Health Program and the American Lung Association are partnering to provide the Open Airways for Schools program statewide, and the Respiratory Health Program and the Indoor Environment Program are providing Tools for Schools assessments statewide. Over 250 child care providers have been educated in the management of asthma, and approximately 50 health care providers statewide have been trained in the appropriate diagnosis and treatment of asthma. Additionally, the Respiratory Health Program has trained over 300 Head Start staff and 300 Head Start parents in methods to decrease exposures to asthma triggers in the home. The Respiratory Health Program is working to reduce bus and other vehicle idling at schools.

We will continue to educate health care providers through an Asthma Educator Institute with the American Lung Association of Washington, and by systematically promoting the newly revised National Heart, Lung, and Blood Institute (NHLBI) guidelines to all health care providers statewide.

While there is no way to know what impact these interventions may be having on hospitalization rates for children, they are all based on best practices, and have been shown to assist other states in decreasing asthma-related hospitalization rates.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	72.6	70.5	68.9	69.0	74.4
Numerator	16985	16834	15798	16145	18177
Denominator	23406	23865	22930	23393	24439
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The Division of Medicaid is continuing to work on a project that educates parents and providers regarding well baby clinics, reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	42.0	38.7	43.3	43.6	46.0
Numerator	235	222	632	1156	1196
Denominator	559	574	1460	2652	2598
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data Source: Medicaid

Notes - 2007
Data Source: Medicaid

Notes - 2006
Data Source: Medicaid

Narrative:
The Division of Medicaid continues to work on a project that educates parents and providers regarding well baby clinics. reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly. We will work with Medicaid and monitor this closely as Medicaid Modernization is implemented in Idaho.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	74.2	74.2	74.0	72.7	72.2
Numerator	15814	16421	17230	17575	17462
Denominator	21314	22142	23296	24172	24180
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

Birth records for 2008 not finalized as of date of entry.

Notes - 2007
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

Birth records for 2007 not finalized as of date of entry.

Notes - 2006
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

Narrative:
Data are for Idaho resident births and are based on records with known data for calculating the Index.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	92.5	87.1	88.6	86.2	84.9

Numerator	150105	128422	124117	125596	122481
Denominator	162240	147366	140163	145682	144221
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Values reflect numbers of children aged <=19.

Notes - 2007
Values reflect numbers of children aged <=19.

Notes - 2006
Values reflect numbers of children aged <=19.

Narrative:
Medicaid data indicate a downward trend from 2004 and 2005 with a slight increase in 2006. It may be difficult to interpret this change as Medicaid reform is implemented. We will watch this indicator closely as changes are made to Idaho's Medicaid system.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	49.2	51.0	55.5	43.3	8.3
Numerator	16759	15345	19392	17821	3405
Denominator	34068	30069	34939	41156	41120
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data Source: Medicaid
Includes Medicaid and Idaho CHIP enrollees only.

Notes - 2007
Data Source: Medicaid
Includes Medicaid and Idaho CHIP enrollees only.

Notes - 2006
Data Source: Medicaid
Includes Medicaid and Idaho CHIP enrollees only.

Narrative:
Medicaid is reimbursing doctors and midlevel providers for topical fluoride applications. Data is from Medicaid. As Idaho implements the Medicaid Modernization Program there will be changes as Medicaid contracts with Blue Cross to cover dental services.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1949	3244	1194	1261	4098
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
As was reported in previous years, chilren who qualify for SSI in Idaho are automatically eligible for Mediciad. Since the Children's Special Health Program only serves children without insurance, this means the numerator remains at zero each year.

Notes - 2006
All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. That is the payment source, rather than Title V, for all rehabilitative services needed.

Incidence data from SSA via Health & Ready to Work website:
www.hrtw.org

Narrative:
Always 0 since CSHP only provides condition-specific coverage for children with no creditable health insurance. In Idaho, any child who qualifies for SSI becaomes automatically eligible for Idaho Medicaid, and is therefore ineligible for the Children's Special Health program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	7.9	5.6	6.4

Notes - 2010
Birth records for 2008 not finalized as of date of entry

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	other	7.5	5.5	6.9

Notes - 2010
Death records for 2008 not finalized as of date of entry

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	57.9	75.7	69.6

Notes - 2010
Birth records for 2008 not finalized as of date of entry

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	63.9	76.7	72.2

Notes - 2010
Birth records for 2008 not finalized as of date of entry

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	185

Narrative:
Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all chidren's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:
1) low-income children and working-age adults
2) individuals with diabilities or special health needs, and
3) elders or those otherwise dually eligible for Medicaid and Medicare.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 19)	2008	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children	2008	

(Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 19)		185 185 185

Narrative:
Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all chidren's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:
1) low-income children and working-age adults
2) individuals with diabilities or special health needs, and
3) elders or those otherwise dually eligible for Medicaid and Medicare.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	500

Notes - 2010
Pregnant women are not covered by SCHIP in Idaho unless the woman qualifies as a child. 500% entered because the form requires a value in the range 100-500.

Narrative:
Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all chidren's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:
1) low-income children and working-age adults
2) individuals with diabilities or special health needs, and
3) elders or those otherwise dually eligible for Medicaid and Medicare.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death	3	Yes

certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2010

Narrative:
The manager of the PRATS program is working on a project linking WIC data, birth certificates and PRATS data.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2010

Narrative:
A weighted YRBS survey was conducted in Idaho in 2005, 2003 and 2001.

In 2005, the total percentage in reporting tobacco use in the past month was 21.4% (Males - 27.1% and Females - 15.9%). In 2003, total use was 17.8% (Males - 20.3% and Females - 15.0%), in 2001 the total was 23.4% (Males - 28.3% and Females - 18.0%). Data source is the CDC website. See State Performance Measure 4 for activities.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Idaho's priorities for its MCH population continue to be based primarily on the results of the 5 year needs assessment conducted five years ago.

The health needs of pregnant women are: Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care. The indicators for pregnant women are focused around the following topics: Breastfeeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

The health needs of infants are: Child Abuse, Immunizations, Improving access to care and Disparities in infant mortality. Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic show that Idaho is doing a good job of screening infants. Indicators for infants are focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity.

The health needs of children are: Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease. Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available. Indicators for children are focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

The health needs of adolescents are: Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy. Indicators for adolescents are focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence, the school dropout rate, and the juvenile arrest rate for violent crimes.

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. Access to Care, however, is the highest priority need for this population. The other two issues considered are availability of specialty care and inadequate data. Indicators for Idaho's CSHCN population are focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

The Title V Maternal and Child Health Block Grant directly funds programs and support services to address most of the issues identified as priority areas for Idaho's MCH population. They include: Reproductive Health, Children's Special Health Program, Oral Health, Epidemiology Services, Genetics, Newborn Hearing Screening, Perinatal Assessment, Injury Prevention, Child Mortality Review Team, Suicide Prevention, MCH Research and Data Analysis, and the Idaho CareLine.

/2006/ Idaho has just completed it's 5 year needs assessment. A contractor, Health Systems Resarch, performed the needs assessment. The assessment included several meetings with key stakeholder, key informant interviews, focus groups, general and population specific surveys, review of secondary data and a capacity assessment among state level MCH personnel. Priority needs are listed in the next section. //2006//

B. State Priorities

1. To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services.
2. To reduce the adolescent pregnancy rate through improved access to contraceptive services.
3. To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents.
4. To increase access to care including oral health - (not limited to focusing on health insurance) - targeting women, infants and children and children with special health needs.
5. To increase prenatal care utilization focusing on population disparities.
6. To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age.
7. To reduce morbidity/mortality due to injury.
8. To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STD's.
9. To reduce infant morbidity/mortality by review of infant/child deaths by the Child Mortality Review Team, followed by targeted interventions.
10. To increase capacity for "cluster" investigation/surveillance and to increase data capacity for all MCH populations.

/2006/ Below is a list of priority areas that were identified during Idaho's 5 year MCH needs assessment. They are not in order of priority, but rather a list of the 10 key areas needing attention.

Priorities:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for pregnant women and children across provider and community networks.

2. Perinatal Depression: Identify screening tools and work with state professional groups and the regional perinatal coalitions to develop mechanisms to assure appropriate use of the tools and availability of referral resources for perinatal depression.

3. EPSDT screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring as appropriate for all infants, children and adolescents.

4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.

5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex care needs of all CSHCN.

6. Cultural Competency: Improve cultural competency across all programs that work with the Maternal and Child Health population.

7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.

8. Health Education: Strengthen health education in the public schools, including developing strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing system collaboration efforts that focus on defined outcomes for the MCH population. Start building the infrastructure within MCH programs to sustain efforts over time and work to include all MCH partners when planning and targeting efforts.

10. Overweight and obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children. //2006//

/2008/ A number of factors over the past year have greatly influenced Idaho's MCH Title V program and the state priorities that were identified in the 2006 application. Below is a list of state priority areas that currently reflect the need of Idaho's MCH population. These are not in priority order; they are presented as a list of 7 key areas needing attention.

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.

2. Public Health will work with Medicaid to explore options to maximize services to the MCH population.

3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.

4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2 years of age.

5. Work with Medicaid, the newly formed Division of Behavioral Health and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.

6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.

7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy. //2008//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100

Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	16	28	17	31	30
Denominator	16	28	17	31	30
Data Source					Idaho Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

In July of 2008 Cystic Fibrosis was added to the panel of conditions for which all children in Idaho (unless the parents opt out) are screening. In 2008 99.5% of all children born in Idaho were screened for all of the conditions on the March of Dimes recommended panel, plus several conditions which are beyond the panel.

In 2008 the Children's Special Health Program hired an RN, Senior whose primary task is the oversight of the newborn screening program, and educational activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide education/technical assistance to birthing facilities and midwives in all regions of the state.			X	X
2. Idaho NBS staff assist in short-term follow-up of presumptive positive cases.		X	X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In-service trainings are ongoing at all birthing centers in Idaho, and - as needed - as physician's practices where second screening samples are drawn. This year the RN overseeing the program was successful in presenting in-services trainings at Mountain Home Air Force Base near Boise. Historically MHAFB has been reticent to have state staff train their personnel.

c. Plan for the Coming Year

Idaho continues to focus efforts on increasing the compliance with the recommended (not mandated) 2-screen system. Currently Idaho's compliance with the two screens is above 85%. The Program may open the newborn screening rules next legislative session in an attempt to mandate the second screen.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	60	60	60	53
Annual Indicator	57.2	57.2	57.2	52.7	52.7
Numerator					
Denominator					
Data Source					National Survey of CSHCNs 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	53	53	53	53	53

Notes - 2008
This number is from the 2005-2006 CSHCN Survey

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
While preparing for making changes to the Rules Governing the Idaho Children's Special Health Program, CSHP took the show on the road, holding public comment sessions in Northern, Eastern and Southern Idaho. Input from patients and their families was sought, and the comments received impacted the rule-making proccess.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner with non-profit family-oriented organizations to provide technical assistance and funding support.		X		X
2. Participate in the Developmental Disabilities Council and the Early Childhood Coordination Council, which include fmaily		X		X

members.				
3. Solicit family input on Administrative Rules Changes		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Rules change proccess begun last year was finalized in April of this year, resulting in CSHP being allowed to provide medical foods in addition to folrmula to Idaho's children with PKU.

CSHP staff continue to service on various councils and advisory boards such as: Idaho Parents Unlimited, the Developmental Disabilities Council andIdaho Sound Beginings. In addition CSHP has forged a relationship with Idaho Familes of Adults with Disabilities (IFAD). This year CSHP was able to provide some limited financial support, and in return received excellent input and advice into our Transition-to-Adulthood materials development process.

CSHP staff presented a Transition-to-Adulthood session as the Idaho Tools for Life conference earlier this year.

c. Plan for the Coming Year
With the program being under travel restrictions, CSHP staff will experience limited travel options in the coming year. CSHP will continue to be active in in-state commitments, working groups, etc, and will continue to develop the new relationship with Idaho Families of Adults with Diabilities.

CSHP's Transition-to-Adulthood trainings will continue at conferences around the state.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	52	52	52	52	52
Annual Indicator	49.1	49.1	48.8	47.7	47.7
Numerator					
Denominator					
Data Source					National Survey of CSHCNs 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	52	52	52	52	52

Notes - 2008
From the 2005-2006 CSHCN Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Last year CSHP undertook and completed a project where the file on each of CSHP's currently enrolled children, was analyzed to see if the child might be eligible for Medicaid. For those children who were suspected of being eligible, CSHP's contractor worked with each family to complete a streamlined Medicaid application process.

Through this project CSHP was able to move 8 children from CSHP over to Medicaid, where they receive comprehensive medical coverage instead of condition-specific coverage. Eight children does not seem like a large number, but since CSHP currently has less than 200 children enrolled in the program, 8 children is a bit over 4% of the total patient load.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHP conducted a project to move CSHP kids over to comprehensive care within Medicaid.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This year, CSHP continues to work with patients applying for coverage through CSHP to also complete a Medicaid application. The condition-specific coverage offered through CSHP is no Medical Home, whereas coverage through Medicaid is more likely to fill the Medical Home criteria.

c. Plan for the Coming Year
CSHP will continue to try to enroll applicant into the Medicaid system, and continues to participate in conference calls and other informational session regarding Medical Homes. Using the information garnered from these session, CSHP remains open to opportunities to impact this indicator in Idaho.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	60	60	60	60	60
Annual Indicator	53.3	53.3	53.3	56.9	56.9
Numerator					
Denominator					
Data Source					National Survey of CSHCNs 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	60

Notes - 2008
From the 2005-2006 CSHCN Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSHP continues to provide condition-specific coverage for Idaho's children within certain diagnostic categories, which has a slight positive impact on this indicator.

Also, as mentioned along with NPM 3 - Last year CSHP undertook and completed a project where the file on each of CSHP's currently enrolled children, was analyzed to see if the child might be eligible for Medicaid. For those children who were suspected of being eligible, CSHP's contractor worked with each family to complete a streamlined Medicaid application process.

Through this project CSHP was able to move 8 children from CSHP over to Medicaid, where they receive comprehensive medical coverage instead of condition-specific coverage. Eight children does not seem like a large number, but since CSHP currently has less than 200 children enrolled in the program, 8 children is a bit over 4% of the total patient load.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHP continues to provide condition-specific covereage to CSHCNs with no health insurance.		X		
2. CSHP conducted a project to move CSHP kids over to comprehensive care within Medicaid.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As applicants apply to receive services through CSHP, CSHP staff and contractors continue to work with each family to complete the Medicaid application proccess. This process is undertaken whether or not the child is found to be eligible for CSHP.

c. Plan for the Coming Year
CSHP has systemized the practice of working with applicant familes toward Medicaid eligibility, and this facilitation effort will continue.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	80	80	80	80	86
Annual Indicator	75.2	75.2	75.2	86	86
Numerator					
Denominator					
Data Source					National Survey of CSHCNs 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	86	86	86

Notes - 2008
From the 2005-2006 CSHCN Survey.

Last year this indicator was mistakenly reported as 85.9

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The Children's Special Health Program (CSHP) used to manage - and continues to fund - the only genetics and metabolic medical services available in Idaho. Last year the genetics program took a huge step in moving from state facilities and state staff, into a hospital. St. Luke's Children's Specialty Center (CSC) is the only children's hospital in Idaho, and now houses the genetics clinics in addition to the cystic fibrosis clinic which has been held at St. Luke's CSC for the past several years.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use and build upon existing relationships with advocacy and support organizations to provide educational and information materials through meetings, conferences and newsletters.		X		X
2. Genetics and metabolic clinics, which were previously state-run, have been transfered to appropriate medical facilities.	X		X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In February of this year, the last state "owned" clinic was also transferred to St. Luke's CSC, although it is still completely financially supported through CSHP. This final transfer of clinical services from state facilities to a medical environment, provides a better quality and more convenient service to the people of Idaho.

c. Plan for the Coming Year
While CSHP, with MCH funds, supports as much of the genetics and metabolic clinics as possible, there continues to be an unmet need in Idaho as is demonstrated by the waiting list to access these clinics. During the coming year, CSHP will be working with St. Luke's Hospital to look at options, other than increased funding, to provide additional services to reduce the waiting lists.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6	6	6	6	46
Annual Indicator	5.8	5.8	1	45.8	45.8
Numerator					
Denominator					
Data Source					National Survey of CSHCNs 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	46	46

Notes - 2008
From the 2005-2006 CSHCN Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. Prior years reported the national measure rather than Idaho's measure.

a. Last Year's Accomplishments
Last year CSHP's new RN, Senior began work on a Transition-to-Adulthood curriculum. The RN, Carol, came to Idaho's program from a regional CSHCN program in Florida where she was heavily involved in Transition issues. She drew on her experiences from her previous position, and various materials developed by other state's Title V programs, to develop and adapt materials suitable for Idaho.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition-to-adulthood curriculum has been developed and piloted with CSHCNs in Idaho.		X		X
2. Transition-to-adulthood activities such as direct-mailings, and linkages are being developed and should begin summer of '09.		X		X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Early this year the new Transition-to-Adulthood curriculum was piloted at the Tools for Life Conference. Later this year, CSHP will begin mailing transition materials to all enrollees who are approaching their 18th birthdays.

CSHP has partnered with Idaho Familes of Adults with Disabilities (IFAD) which, among other things, begins working with CSHCN's at the age of 14 on transition to adulthood. So far in 2009 CSHP has been able to provide limited financial support to IFAD, and has participated in informational resource exchanges as we both develop our materials on transition.

c. Plan for the Coming Year
The Transition-to-Adulthood materials will continue to be modified and presented at available opportunities. Mailings to CSHP program participants will continue, with additional materials becoming available for other transition points such as transition to elementary school, and transition to teenage years.

CSHP will continue to develop the partnership with IFAD during this and the coming year.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	81	82	83	83
Annual Indicator	80.8	78.1	77.8	75.8	75.8
Numerator					
Denominator					
Data Source					NIS 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83	83	83	83	83

Notes - 2008
NIS data for CY2008 is not available until August, 2009. 2007 value used as estimate for 2008, Four or more doses of DTaP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB

The percentages come from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2007
NIS data for CY2007 is not available until August, 2008. 2006 value used as estimate for 2007, Four or more doses of DTaP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB

The percentages come from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2006
NIS data for CY2006 is not available until August, 2007
The percentages come from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

a. Last Year's Accomplishments
The Idaho Immunization Program (IIP) completed provider education conferences this past year. These are regional conferences held throughout the state focused on: increasing vaccine coverage, vaccine management and safety, provider education, reminder/recall of patients due for immunizations, and parent education. The Program also continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services. This includes screening every WIC child's immunization record at certification and re-certification visits to verify they are up-to-date. The program also continued to monitor immunization coverage levels within the Medicaid population.

The IIP conducted quality assurance reviews with 190 VFC providers in 2008. The IIP was able to meet the goal of visiting 2/3 of Vaccines For Children (VFC) providers.

The IIP continued to offer immunization training opportunities to medical assistant and nurse training programs through the state.

The IIP has over 90 data exports from provider electronic health record systems into the Immunization Reminder Information System (IRIS) and is continuing to work on additional systems. The IIP standardized IRIS trainings into modular trainings and conducted instructor trainings with the health departments. The IIP conducted the first assessment of all providers using IRIS and assiged a usage level. Providers received awards at Shot Smarts based upon their utilization of IRIS.

The IIP bean an aggressive media campaign aimed at increasing immunization rates in late 2008.

The Immunization Program provided all vaccines, except HPV vaccine, free of charge for children 0 through 18 years of age at public and private provider sites throughout Idaho.
The IIP saw a decrease in the number of children receiving the following vaccines: DTaP, IPV, MMR, Hib, Hepatitis B, and Varicella.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free vaccine to all children 0 through 18 years of age by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.			X	
2. Perform annual site visits to VFC providers and conduct provider education.			X	

3. Provide parent, school and daycare education, media and training.			X	
4. Maintain an immunization registry, which includes data quality monitoring.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Immunization Program is working closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the IIP will re-developed the Quality Assurance program so that it targets immunization providers that do not have a minimum of 80% coverage level for the 4:3:1:3:3:1 (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella) immunization series. The IIP will be conducting Focus Groups around the state to gain insight on ways to increase immunization levels and increase communication with the medical community. The IIP also plans to visit approximately two-thirds of all VFC providers in 2009 with Quality Assurance Reviews (QAR).

The IIP is continuing to work on exports from provider electronic health record systems into IRIS. The IIP will continue assessing IRIS usage with providers and assigning a usage level. Providers will continue to receive awards based upon their utilization of IRIS.

The IIP has contracts with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth.

c. Plan for the Coming Year
The IIP will no longer offer vaccines universally, but will offer vaccine for the VFC-eligible population only beginning July 1, 2009.

The IIP will continue implementing a strategic plan to increasing immunization rates. Regional and local training conferences will also continue to encourage, educate and reward providers for their efforts.

The Immunization Program will continue to work with health departments, private providers, and community migrant health centers to make immunizations more available to parents. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

During CY 2009, the Immunization Program will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will also implement and maintain a new registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series. The IIP will implement a Hospital Quality Assurance Program that addresses standing orders for the birth dose of hepatitis B vaccine.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the Immunization Program will continue to conduct or contract for activities in four major areas:

(1) parent education, (2) provider education, (3) reminder/recall, and (4) childcare and school education.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	15	14	13	15	17.8
Annual Indicator	16.8	16.8	17.9	19.0	19.0
Numerator	525	532	597	626	626
Denominator	31340	31738	33264	32974	32974
Data Source					Estimate from prior year
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17.7	17.6	17.5	17.4	17.4

Notes - 2008
Population not available until July 2009. Used population estimate from 2007 as estimated denominator

Notes - 2007
Population not available until July 2008. Used population estimate from 2006 as estimated denominator

Notes - 2006
Population not available until July 2007. Used population estimate from 2005 as estimated denominator

a. Last Year's Accomplishments
During CY 2008, family planning clinics around the state served a total of 3,014 teens aged 15-17 years of age compared with 3,135 teens aged 15-17 years of age who received services in CY 2007. That is a decrease of 14.96 percent, or 451 clients, who were served in CY 2008. Idaho's 2008 teen pregnancy rate for 15-17 year olds is 19.0 percent (provisional data). The 2007 teen pregnancy rate was 19.0 percent. The data show a slight increase in teen pregnancy rates for 2005 and 2006 and no change in the rates for 2007 and 2008.

The 15-17 year old teen clients received a physical assessment, education, and counseling services. All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STI / STD prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to teens through the public health districts.	X		X	
2. Develop comprehensive educational messages targeted to teens.		X	X	X
3. Continue to conduct Teen Education Afternoon (TEA) local district clinic project.		X	X	
4. Continue program collaboration and coordination activities with the Adolescent Pregnancy Prevention Program.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Pregnancy Prevention (APP) Manager, the Family Planning Coordinator, and the STD Prevention Coordinator meet together periodically to discuss collaboration and coordination efforts between their programs.

All the local health districts have active advisory boards within their family planning programs which guide the content of education materials and provide direction for outreach activities. All of the advisory boards have committee members of various backgrounds including faith based members and teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups.

All health districts provide family planning services to teen clients. Many districts provide extended clinic hours in the evening to accommodate teen client's schedules.

c. Plan for the Coming Year

Program collaboration, coordination, and integration activities will expand as program coordinators from the Family Planning, STD, and HIV Programs (FPSHP) continue to conduct integrated on-site program reviews of their respective programs at health districts. Technical assistance will focus on providing ideas on how to streamline and integrate program service delivery activities across all the programs within the FPSHP.

Comprehensive educational messages will continue to be developed that target teens and provide information on issues like abstinence, STIs, parental involvement, sexual coercion, and birth control methods.

The Teen Education Afternoon (TEA) clinic continues to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling, and up-to-date information on hot topics occurring within the he4alth district. Client-centered, one-on-one counseling is also provided.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	62	64	66	60	60.5
Annual Indicator	50.1	55.7	55.7	55.7	55.7
Numerator	370	10315			
Denominator	739	18527			
Data Source					Smile Survey 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60.6	60.7	60.8	60.8	60.8

Notes - 2008
SMILES survey used to estimate will not conclude until June 2009. 2005-06 rate used as latest available estimate.

Notes - 2007
SMILES survey used to estimate not conducted in 2007. 2005 rate used as latest available estimate.

Notes - 2006
SMILES survey used to estimate not conducted in 2006. 2005 rate used as estimate.

a. Last Year's Accomplishments
Contracts with the seven district health departments continue to provide dental sealants, fluoride varnish, and fluoride mouthrinse in participating schools that have >51% of children eligible for free and reduced school lunch and no fluoride in the community water supply. The Smile Survey data collection will be completed June 2009. The Idaho Oral Health Alliance (IOHA) held two member meetings. IOHA members are working with the Idaho Oral Health Program (IOHP) to develop a five-year strategic plan and compile a comprehensive state oral health burden report. The IOH Plan and burden report will be available Fall 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V support for oral health programs will be maintained at current level.			X	
2.				
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
The program manager position was vacant from 2/08-7/08. The new program manager and the chief of the Bureau of Community and Environmental Health (BCEH) amended the seven health district contracts to redefine the contract year to cover July 1 through June 30. This schedule aligns the health district contract to reflect the school year.

c. Plan for the Coming Year
The new health district contracts move to level funding. Funding variations occurred in the fluoride mouthrinse programs. Some districts worked with more schools than others and received more funding. Adjustment to funding will result in slightly fewer schools participating in the fluoride mouthrinse program, most likely those schools that had poor compliance with the program. Several health districts will increase their varnish and sealant programs as a result of increased funding.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.5	4	4	4	5.5
Annual Indicator	5.5	5.8	4.0	7.7	2.9
Numerator	17	18	13	26	10
Denominator	308270	308945	325906	339358	339358
Data Source					Dept of Transportation
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5

Notes - 2008
Death count preliminary total from Idaho Dept of Transportatio for 2008. IDT records usually reflect deaths at the scene of an accident and therefore will be lower than subsequent death certificate data.

Population count for 2008 not available until July 2009, 2007 population estimate used as estimate.

Notes - 2007

Death count preliminary total from ISP for 2007
Population count for 2007 not available until July 2008, 2006 population estimate used as estimate.

Notes - 2006
Death count preliminary total from ISP for 2006
Population count for 2006 not available until July 2006, 2005 population estimate used as estimate.

a. Last Year's Accomplishments
In recent years, the focus of injury prevention program planning has been on fall prevention in elders over the age of 65. The Injury Prevention & Surveillance Program, strengthened it working relationship with the Idaho Transportation Department (ITD) Office of Highway Safety in its efforts to improve traffic and pedestrian safety among Idaho youth. Program goals have been established to look beyond the burden of motor vehicle crashes to youth and in collaboration with the Office of Epidemiology, has set objectives to collect and analyze fatal and non-fatal injury data associated with both poisoning episodes and pedestrian injuries, particularly in youth aged 14-years and younger.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Although the Injury Prevention Program will continue to monitor mortality rates for those 14 years and younger caused by motor vehicle crases, it will shift focus to poison control and pedestrian-related traffic crashes.			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Injury Prevention & Surveillance program manager, in cooperation with the Rocky Mountain Poison and Drug Center (RMPDC), is evaluating possible alternative funding sources in support of the Idaho Poison Control Center contract.

The Injury Prevention & Surveillance program manager, in cooperation with the state Safe Routes to School (SR2S) Coordinator and the ITD Office of Highway Safety, are linking information from available data sources to examine pedestrian-related traffic crashes. This information will be used to foster more pedestrian friendly and safe environments in Idaho communities. Idaho was selected recently to participate as a state member in the STIPDA Pedestrian Injury Prevention State Workshop, Washington, D.C., June 2-3, 2009.

c. Plan for the Coming Year
Additional efforts will be focused on improving data collection and surveillance for poisoning episodes and pedestrian injuries among youth age 14-years and younger. As Idaho is not a funded CORE Program state under the CDC National Center for Injury Prevention and Control

(NCIPC), Public Health Injury Surveillance and Prevention (PHISP) Program, we continue to seek a sustainable source of adequate funding for injury prevention programs.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			50	51	51.5
Annual Indicator		49.8	50.5	54	50.5
Numerator					
Denominator					
Data Source					PRATS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52	52.1	52.2	52.2	52.3

Notes - 2008
Data source is 2007 Idaho PRATS survey. Data for 2008 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2007
Data source is 2006 Idaho PRATS survey. Data for 2007 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would the results of weighted survey sample data.

a. Last Year's Accomplishments
1) In FY09, the State Office supported efforts of Local Breastfeeding Coalitions to provide trainings for healthcare professionals and community members who work with populations that would benefit from breastfeeding education to meet specific needs for their area including sponsoring Paula Meier Health Outcomes of Breastfeeding at the Idaho Perinatal Project conference and Amy Spangler Breastfeeding -- What Every Healthcare Provider Needs to Know at the Biannual WIC Conference.

2) The State Breastfeeding Workgroup developed and implemented materials on best practices for Idaho Breastfeeding Peer Counseling Programs. These included strengthening training protocols, research based recommendations on contact procedures to increase breastfeeding

duration, and updated exit survey to continue to evaluate the effectiveness of the program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Breastfeeding Best Practice Grants for community coalition training and World Breastfeeding Week activities.		X		X
2. Provide technical assistance to Breastfeeding Peer Counseling Programs to implement best practices as part of revised Idaho Breastfeeding Peer Counseling Plan.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) The State Breastfeeding Workgroup is currently developing training materials related to breastfeeding as part of implementing the new WIC food packages.

2) The State WIC Program continues to provide Local WIC Agencies with Best Practice Grants to achieve higher standards in breastfeeding education and support. Part of the grant requires implementation of World Breastfeeding Week activities.

c. Plan for the Coming Year

1) In FY10, the State Office will continue to work with the State Breastfeeding Workgroup and Local Breastfeeding Coalitions to develop materials needed related to breastfeeding and implementation of the new WIC food packages.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	98.8
Annual Indicator	94.2	94.6	98.4	96.7	97.9
Numerator			22302		
Denominator			22657		
Data Source					PRATS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98.8	98.8	98.8	98.8	98.8

Notes - 2008
Data source is 2007 Idaho PRATS survey. Data for 2008 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data. Rate is among those children who had their hearing tested at all.

Notes - 2007
Data source is 2006 Idaho PRATS survey. Data for 2007 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses indicating that the baby was tested after hospital discharge or that the baby was not born at a hospital but was tested were not included in the denominator.

a. Last Year's Accomplishments
Five Idaho audiologists were granted scholarships to attend nationally accredited training in pediatric audiology with the stipulation that they provide two trainings in-state on their return. Training was provided to hospital staff, early interventionists and others during the 2008 Idaho Hospital Association conference in Northern Idaho. Site visits and trainings were conducted at 11 hospitals around the state and included regional early intervention staff and other players. A survey was conducted of Idaho audiologist's to assess their continued interest in pediatric services and their capacity to provide such services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Planning and collaboration for improved surveillance and tracking system.				X
2. Match or exceed the national benchmarks set by the JCIH 2007 Guidelines.			X	
3. Increase family to family support and access to information for families.		X		
4. Expand newborn hearing screening to other community-based sites.			X	X
5. Increase and improve the participation of physicians in EHDI and the provision of a medical home.				X
6. Assess needs of EHDI providers with regards to increased data integration, including upgrading to a web based data tracking system.				X
7.				
8.				
9.				
10.				

b. Current Activities
Currently the Idaho EHDI program is collaborating with other stakeholders to refine the data surveillance and tracking system. The feasibility of a web based tracking system is being evaluated along with possibilities for integration with other programs. As part of this refinement, the Idaho Sound Beginnings referral/results form is being redesigned.

Continuous surveillance and tracking of Idaho's babies continues as well as the regular monitoring of hospital data reports for quality assurance and to determine training needs.

c. Plan for the Coming Year
Regular education, health promotion and training activities will continue. Temporary help has been added to assist with data tracking and follow-up. Outreach efforts are being expanded with audiologists in response to the results of the audiology survey. Outreach will include the provision of educational training and materials, The Educational Consultant will be collaborating directly with the audiologists to ensure that families are informed of the importance of following through with diagnostic testing in order to decrease the incidence of 'lost to follow-up.' Increased collaboration with the Part C program will include assessing feasibility of data integration between programs.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	12	12	12	11.2	12.5
Annual Indicator	13	13.0	11.4	13.0	11.0
Numerator		19177	44995	52135	45621
Denominator		147366	394435	401854	414662
Data Source					Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.4	12.3	12.3	12.3	12.3

Notes - 2008
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2007

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Objectives in future years may be higher than current performance. The data source tends to have swings from year to year due to nature of the survey.

Notes - 2007
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2007

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Notes - 2006
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2006

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

a. Last Year's Accomplishments
In early 2008 the focus was on promoting health coverage for those children eligible but not yet enrolled in either Idaho Medicaid or SCHIP. As the year progressed and the economy turned ever more downward, focus shifted to finances. The need to reduce expenditures resulted in decisions to reduce benefit packages rather than restrict eligibility.

The economic downturn coupled with the removal of resource limits did result in and increase in enrollment in SCHIP (3.96%) and Idaho Medicaid (69.18%). The goal was to increase the number of children enrolled in the Title XXI programs by 2,000 during 2008. The actual increase in enrollment over 2007 was 4,231 children. While the targeted increase (6,000) for Title XIX was not met, enrollment increased (1,218) for the first time in four years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to implement expanded CHIP coverage through child-only health care applications.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Idaho conducted a targeted mailing to those families who had children enrolled in WIC, but not enrolled in health coverage. Less than 1% of families responded by submitting an application.

Idaho monitors the number of children denied for having creditable insurance who subsequently are found eligible within a six month period (dropped insurance). The small number of children identified indicates that substitution of coverage is minimal (<1%).

c. Plan for the Coming Year

Idaho continues to assess methodologies to target outreach activities to best reach those children who are eligible, but not enrolled. The annual Back-to-School campaign remains the cornerstone of Idaho's outreach and is considered a best practice. Idaho has also found that helping provide coverage for adults has resulted in more children being covered. As further reductions in expenditures are required, benefits will be pared back to more closely approximate available state and federal funding. Medicaid and Title V will continue to partner with Healthy Tomorrows Project to address health insurance issues for children and youth.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			26	31	31
Annual Indicator		28.9	32.1	31.2	31.3
Numerator		5240	5807	5894	6762
Denominator		18137	18113	18862	21581
Data Source					State WIC Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30.9	30.8	30.7	30.6	30.6

Notes - 2008
Based on PedNSS data avail as of 1/17/2009

Notes - 2007
Based on PedNSS data avail as of 1/17/2008

Notes - 2006
Based on PedNSS data avail as of 1/16/2007

Changes in unit conversion measures and BMI comparison data from 2005 reduce comparability with previous data. Using method for 2006 data values for previous years would be:

2002 29.0 percent
2003 28.2 percent
2004 29.4 percent
2005 31.3 percent

a. Last Year's Accomplishments
WIC Participated in the Idaho Hunger Taskforce and the October 2008 Statewide Hunger Summit.

WIC and the Idaho Physical Activity and Nutrition Program partnered on a healthy lifestyle calendar that provides ideas for incorporating healthy food an activity choices. The calendar was distributed statewide. 40,000 copies were printed for distribution.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Participated in the Idaho Hunger Taskforce and the October 2008 Statewide Hunger Summit.				X
2. WIC and the Idaho Physical Activity and Nutrition Program partnered on a healthy lifestyle calendar that provides ideas for incorporating healthy food an activity choices. The calendar was distributed statewide.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Discussion for project ideas with the Idaho Physical Activity and Nutrition Program continues on an ongoing basis.

c. Plan for the Coming Year
Will continue discussion for project ideas with the Idaho Physical Activity and Nutrition Program.

Participation in the Hunger Taskforce will continue.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			8	8	8.5
Annual Indicator			9.4	9.0	8.7

Numerator			2258	2255	2144
Denominator			24112	24972	24642
Data Source					Birth certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.5	8.4	8.4	8.3	8.3

Notes - 2008
Out of state birth certificates do not necessarily include smoking during pregnancy. Denominator reflects those that do record smoking status, births to Idaho women.

Notes - 2007
Out of state birth certificates do not necessarily include smoking during pregnancy. Denominator reflects those that do record smoking status.

Notes - 2006
Out of state birth certificates do not necessarily include smoking during pregnancy. Denominator reflects those that do record smoking status.

a. Last Year's Accomplishments
Less than 1% of pregnant women who smoke call the QuitLine or register for QuitNet. This number did not change when we ran our KISS campaign and has not increased with the Health Districts efforts. This was a project specifically targeted at pregnant women who were smoking and addressed the effects of second hand smoke on infants and children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide family planning services to educate pregnant women on the risk of tobacco use.	X		X	
2. Provide WIC services to pregnant women.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All of the quit coaches for QuitLine and QuitNet as well as the instructors for local classes are trained to work with pregnant women but we are not currently nor do we plan on running any special advertising targeting pregnant women. WIC continues to address smoking in pregnant

women and make referrals as necessary. Additionally, education is provided in family planning clinics. Title V funds will continue to support the PRATS survey to monitor this measure.

c. Plan for the Coming Year
Funding for QuitNet and QuitLine has been reduced. Contracts with local health districts are half of what they were in the previous year. Education efforts in WIC and family plannning will continue as will funding for PRATS.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	13	12	11	8.5	11
Annual Indicator	13.8	9.1	11.7	18.9	18.9
Numerator	15	10	13	21	21
Denominator	108840	109731	110742	110959	110959
Data Source					Death Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.9	10.9	10.9	10.9	10.9

Notes - 2008
2008 death records have not been finalized, 2007 deaths have been used as best estimate.
2008 population by age not available at time of entry, 2007 used as best estimate.

Notes - 2007
2007 death records have not been finalized, 2006 deaths have been used as best estimate.
2007 population by age not available at time of entry, 2006 used as best estimate.

Notes - 2006
Not all death records for 2006 have been received.
2005 population data is used as estimate for 2006.

a. Last Year's Accomplishments
The Youth Suicide Prevention Project (YSP) at Idaho State University trained approximately 550 adult gatekeepers this past year. Trainings focus on mental health, child trauma, stigma and suicide awareness and intervention. New, specifically designed trainings for school faculty and staff, cultural groups and juvenile justice personnel were developed to expand the reach of the program. The project continued to disseminate evidence-informed materials to community organizations working on suicide prevention. As YSP presented this information across the state in Year 3, communities in Idaho are beginning to accept evidence-informed materials more readily. Staff continues to work with cultural groups interested in trainings and materials for their

suicide prevention efforts in Hispanic, Asian American and American Indian communities. YSP staff shared information about the project on a national and local level during this year. For example, our Project Director spoke at the STIPDA national conference and our poster entitled, "Promoting Evidence Informed Practices with Community Outreach" was displayed at the NIMH Outreach Partners conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Youth Suicide Prevention Early Intervention Coalition, a State-level public / private partnership.				X
2. Provide gatekeeper training for university residence hall staff, other student staff and community gatekeepers.				X
3. Statewide suicide prevention referral sources will be available through 2-1-1 Idaho Careline		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

YSP received a No Cost Extension beyond the end of the grant year (May 31, 2009) to conduct final activities and close out the grant. Trainings are continuing to a limited extent as well as cultural outreach, funding permitting. A great deal of attention is being be focused on the data collection and analysis portion of the project. A new YSP grant application has been submitted and an award decision from the Substance Abuse and Mental Health Services Administration is due October 1, 2009. We continue to distribute a large amount of evidence-informed materials to communities. Some of these materials are distributed at conferences, gatekeeper trainings and many during in-person consultations. Additional in person consultations are requested on a regular basis. ISU is negotiating a contract with the Idaho Department of Health and Welfare to research, plan and test a suicide prevention hotline for Idaho. Idaho is one of two states nationally without a certified hotline.

c. Plan for the Coming Year

If funded, Idaho State University will conduct a new Awareness to Action Youth Suicide Prevention Project (AAYSP), which would go into effect October 1, 2009. An Awareness to Action Academy is planned to support community groups to advocate for suicide prevention and support mental health professionals in learning methods for identifying and intervening with patients at risk of suicide. Additional components of the grant application include customized gatekeeper trainings including groups such as foster parents, caregivers for youth who are at high risk due to a previous suicide attempt, and GBLT youth. ISU also is expected to conduct a research and implementation study through June 30, 2010 to develop plans for a suicide prevention hotline in Idaho, if current contract negotiations are successful.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75	75	75	75	75
Annual Indicator	99	99	99	99	99
Numerator					
Denominator					
Data Source					No reliable data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	75	75	75	75

Notes - 2008
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

Notes - 2007
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

Notes - 2006
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

a. Last Year's Accomplishments
Efforts in this area continued to be centered around the lay midwife project. Title V provided funding for continued outreach and education. This project was aimed at improving the general knowledge of lay-midwives regarding services availaable, important medical screenings and important medical benchmarks. The Idaho Perinatal Project holds the contract for these activities. Work also continued around efforts to establish midwife licensure requirements in Idaho.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2. The contractors with the family planning programwill provide	X			

pregnancy testing and make referrals as appropriate.				
3. With the passage of the Midwife Licensure Bill support partners in the rule making process and implementation of licensure.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This has been the fifth year of funding for this project. The original thought was funding for four years. Educational and outreach activities have continued. During this year strained budgets, the decision was made to discontinue funding the Idaho Perinatal Project for these activities. The Project has made great headway in education and outreach and has established a well rounded lending library for practioners. The Title V / Perinatal Project partnership continues to be strong and other contracting opportunities will be considered as they arise.

During the 2009 Legislative Session, efforts were successful in passing a midwife licensure bill. The Idaho Perinatal Project Advisory Board was instrumental in this success.

c. Plan for the Coming Year

During the coming year Administrative Rules guiding the implementation of the Midwife Licensure Bill will be promulgated. Title V will support these efforts. Title V will continue to support the PRATS survey and work with the Perinatal Project, Early Childhood Coordinating Council and other partners to address this measure.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	84	85	86	78	73
Annual Indicator	71.9	71.4	71.7	71.7	69.6
Numerator	15455	15889	16772	17399	16902
Denominator	21502	22245	23391	24263	24294
Data Source					Birth certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73.2	73.2	73.2	73.2	73.2

Notes - 2008

2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record

The PRATS survey has a self-reported rate of 86.5% among responses to the survey.

Notes - 2007
2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

Notes - 2006
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

a. Last Year's Accomplishments
During CY 2008, 25,627 women received counseling from the family planning program. Of those women, 2,555 were found to be pregnant. Those women who were pregnant were screened for high risk behaviors and referrals made as indicated. All women were referred appropriately to obstetricians in order to begin early prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Program will provide pregnancy testing and referral for prenatal care.	X		X	
2. Utilize PRATS.				X
3. The WIC Program will provide nutritional counseling and information on other pregnancy risk factors.			X	
4. The Idaho CareLine will provide referrals for prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Women continue to receive program services including counseling from the family planning program. Women found to be pregnant will be screened for high risk behaviors and appropriate referrals will be made. Pregnant women will be appropriately referred to obstetricians in order to begin early prenatal care.

c. Plan for the Coming Year
Women will continue to receive program services including counseling from the family planning program. Women found to be pregnant will be screened for high risk behaviors and appropriate

referrals will be made. Pregnant women will be appropriately referred to obstetricians in order to begin early prenatal care.

D. State Performance Measures

State Performance Measure 1: *Percent of mothers who were screened for post partum depression within three months following delivery.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			75	75	80
Annual Indicator	99	99	99	99	99
Numerator					
Denominator					
Data Source					No reliable data
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	80	80

Notes - 2008
No screening data is available at this time. 99 has been entered to save form.

From the 2007 Idaho PRATS survey 57.0% of women self-report they were "a little depressed," "moderately depressed," or "very depressed" during the 3 months following delivery. This is not entered on the form as it is not the result of any form of clinical screening and the time period does not match that of the measure.

PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2007
No screening data is available at this time. 99 has been entered to save form.

From the 2006 Idaho PRATS survey 55.4% of women self-report they were "a little depressed," "moderately depressed," or "very depressed" during the 3 months following delivery. This is not entered on the form as it is not the result of any form of clinical screening and the time period does not match that of the measure.

PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
No screening data is available at this time. Questions for the PRATS survey are being developed to capture this data. 99 has been entered to save form.

a. Last Year's Accomplishments
Local health districts continue to have a desire to address PPD in their clinics by increasing screening of women seen in their offices. However, the system continues to lack the infrastructure for referral.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support local health district advisory boards which guide education materials and outreach.		X	X	
2. Ada County Juvenile Detention Center project.			X	
3. Reproductive health information through high school classes.		X		
4. Continue to develop comprehensive educational methods targeted to teens.		X		
5. Teen Education Afternoon (TEA) health district clinic.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Interest in PPD remains high particularly as the current economic situation puts additional stress on families. MCH will continue to work with partners to strengthen the infrastructure and improve the systems we have to address this issue.

c. Plan for the Coming Year
Collaboration between stakeholders such as the Idaho Perinatal Project, the Early Childhood Coordinating Council, the Department of Health and Welfare, hospitals, providers, etc. will continue.

State Performance Measure 2: *The percent of Medicaid and SCHIP children ages 1 and 2 that received the expected number of EPSDT screens.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			75	75.2	75.4
Annual Indicator		70.5	67.4	66.4	71.7
Numerator		16834	16430	17301	19373
Denominator		23865	24390	26045	27037
Data Source					Health and Welfare report HWMF_0096
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75.6	75.8	76	76	76

Notes - 2008
Values entered reflect EPSDT screenings for Medicaid and Idaho CHIP enrollees <=1 year of age only.

Notes - 2007
Values entered reflect EPSDT screenings for Medicaid and Idaho CHIP enrollees <=1 year of age only.

Form 17 HSC 02 and 03 combined.

Notes - 2006
Values entered reflect EPSDT screenings for Medicaid and Idaho CHIP enrollees <=1 year of age only.

Form 17 HSC 02 and 03 combined.

a. Last Year's Accomplishments
A considerable amount of effort was put into educating providers that the reimbursement rate for well child checks has increased to match commercial rates. Though a variety of communication means were used, this has been an ongoing effort and seems to be paying off. Up-dated provider hand books were distributed which has also helped.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue education of parents and providers regarding changes to Medicaid Modernization.		X		
2. Continue referrals as necessary for children wo do not have a regular health care provider to establish a medical home.		X		
3. Enhance preventative services targeted to young children and families through Medicaid.	X			X
4. Continue monitoring Medicaid data to evaluate number of children receiving appropriate screens.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Idaho continues to closely monitor data in this area. The reprogramming of the CMS416 report has been successful and is providing accurate data.

c. Plan for the Coming Year
Idaho continues to closely monitor data in this area. The reprogramming of the CMS416 report has been successful and is providing accurate data.

State Performance Measure 3: *Percent of 9th - 12th grade students that report having engaged in sexual intercourse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				36.5	36
Annual Indicator	38.5	39	39	42	42
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013

Annual Performance Objective	35.5	35	34.5	34.5	34.5

Notes - 2008
YRBS Survey in 2007
Results from: RESULTS OF THE 2007 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2006 SCHOOL HEALTH EDUCATION PROFILE, November 2007
Numerator and denominator not available
Most recent data available

Notes - 2007
YRBS Survey in 2007
Results from: RESULTS OF THE 2007 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2006 SCHOOL HEALTH EDUCATION PROFILE, November 2007
Numerator and denominator not available

Notes - 2006
YRBS Survey not conducted in 2006
Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006
used as estimate for 2006
Numerator and denominator not available

a. Last Year's Accomplishments
During CY 2008, family planning clinics around the state served a total of 3,014 teens aged 15-17 years of age compared with 3,135 teens aged 15-17 years of age who received services in CY 2007. That is a decrease of 14.96 percent, or 451 clients, who were served in CY 2008. Idaho's 2008 teen pregnancy rate for 15-17 year olds is xx.x percent (provisional data). The 2007 teen pregnancy rate was 18.2 percent. The data show a slight xxx in teen pregnancy rates for 2005 and 2006 and a slight xxx in the rates for 2007 and 2008.

The 15-17 year old teen clients received a physical assessment, education, and counseling services. All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STI / STD prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support local health district advisory boards, which guide education materials and outreach.		X	X	
2. Continue support of Ada County Juvenile Detention Center project.			X	
3. Reproductive health information through high school classes as supported by local boards.		X		
4. Continue to develop comprehensive educational methods targeted to teens.		X		X
5. Continue support of Teen Education Afternoon (TEA) health distric clinic.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All the local health districts have active advisory boards within their family planning programs which guide the content of education materials and provide direction for outreach activities. All of the advisory boards have committee members of various backgrounds including faith based members and teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups.

All health districts provide family planning services to teen clients. Many districts provide extended clinic hours in the evening to accommodate teen client's schedules.

The Teen Education Afternoon (TEA) clinic in Health District 6 (Southeastern Idaho) continues to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling, and up-to-date information on hot topics occurring within the he4alth district. Client-centered, one-on-one counseling is also provided.

c. Plan for the Coming Year
Comprehensive educational messages will continue to be developed that target teens and provide information on issues like abstinence, STIs, parental involvement, sexual coercion, and birth control methods.

The Teen Education Afternoon (TEA) clinic continues to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling, and up-to-date information on hot topics occurring within the he4alth district. Client-centered, one-on-one counseling is also provided.

The Ada County Juvenile Detention Center project will continue during FY2010. The project provides access to reproductive health care services for high-risk adolescents. Residents will be given the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations will be given to measure the level of intention to the change of risky sexual behaviors.

State Performance Measure 4: *Percent of 9th – 12th grade students who used any type of tobacco in the past 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			21	21	21
Annual Indicator	17.8	21.4	21.4	26.1	26.1
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0	0	0	0	0

Notes - 2008
Based on 2007 YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

Goals are 0 because someone in the past entered a zero and we are not allowed to enter any value larger

Notes - 2007
Based on 2007 YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

Goals are 0 because someone in the past entered a zero and we are not allowed to enter any value larger

Notes - 2006
YRBS not conducted in 2006, 2005 results used as estimate for 2006.
Based on YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

Goals are 0 because someone in the past entered a zero and we are not allowed to enter any value larger

a. Last Year's Accomplishments
Project Filter continued to support the American Lung Association of Idaho in implementation of the Teens Against Tobacco Use (TATU) program in Idaho schools. Project Filter supports the American Lung Association's efforts to implement TATU through our contracts with Idaho's Seven Local Public Health Districts. This past year, the TATU program trained approximately 800 high school students as peer educators who saw over 9,000 elementary and junior high school students. Peer Educators are trained in the TATU tobacco prevention curriculum and receive training on presentation skills. Students are also reached through on campus marketing efforts and school announcements. Project Filter also worked with the Coordinated School Health Coordinator and Department of Education to ensure tobacco-free campus signage was visible on school campuses and draft announcement language to be used during sporting events reminding spectators that all school grounds are tobacco-free zones. Announcements will be read twice during all sporting events, once at the beginning and once half-way through the event. Project Filter staff worked with the Department of Education to review the Health and PE Standards for instruction in relation to what was being taught regarding tobacco education and prevention. The new Health and PE Standards will be used during the 2009-10 school year.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate and implement TATU program in 5 of 7 health districts.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Project Filter supported 6 of 7 Health Districts in working in collaboration with the American Lung Association in the implementation and coordination of their TATU program in Idaho High Schools. Project Filter continues to work with the Coordinated School Health Program and Department of Education to ensure tobacco-free campus signage was visible on school campuses and announcement are read during sporting events to remind spectators that all school grounds are tobacco-free zones. Announcements will be read twice during all sporting events, once at the beginning and once half-way through the event. Project Filter staff worked with the Department of Education to review the Health and PE Standards for instruction in relation to what was being taught regarding tobacco education and prevention. The new Health and PE Standards will be used during the 2009-10 school year.

c. Plan for the Coming Year
Project Filter will continue to support the efforts of the American Lung Association to implement their TATU program in Idaho schools. Project Filter will offer TATU as a menu item that Health District can choose to work as a contract deliverable for next year. Project Filter will continue to work with the Coordinate School Health Coordinator and Department of Education to ensure that tobacco-free school ground policies are being actively enforced.

State Performance Measure 5: *Percent of pregnant women who received dental care during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			50	45	45.1
Annual Indicator	39.3	43.6	43.6	43.4	45.5
Numerator					
Denominator					
Data Source					PRATS
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45.3	45.5	45.5	45.7	45.7

Notes - 2008
Data source is 2007 Idaho PRATS survey. Data for 2008 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2007
Data source is 2006 Idaho PRATS survey. Data for 2007 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses with unknown data were not included in the denominator.

a. Last Year's Accomplishments
Contracts with the health districts were discontinued for this activity. While this kind of prevention program is important, there is not enough funding to develop a coordinated approach to developing a referral system and providing a dental home for pregnant women on Medicaid.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish referral network for physicians and dentists.				X
2. Conduct survey of dentists regarding acceptance of Medicaid referred patients.				X
3. Continue evaluation of PRATS and Idaho Birth Certificate data.				X
4. Continue to improve dental coverage for pregnant women through Medicaid.			X	
5. Educate providers and pregnant women regarding link between good oral health and improved birth outcomes.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
There is no ongoing activity with this program.

c. Plan for the Coming Year
The distribution of printed educational material will continue and note of this important prevention strategy will be included in the new five year state plan (2009-2014). PRATS survey data is still being collected. The planning committee for the Early Years Conference (11/2008) included a speaker that addressed the importance of dental care during pregnancy. These activities will continue to keep the awareness level of this performance measure visible.

State Performance Measure 6: *Percent of Medicaid and SCHIP children who are fully immunized by age 2.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			90	90	90
Annual Indicator		80	65	62.5	83.6
Numerator				210	734
Denominator				336	878
Data Source					Provider assessments
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Data is an estimate from provider visit assessments

Notes - 2007
The rate is calculated from provider assessments.

Notes - 2006
#SP6 Notes – 2005
Data is an estimate from IRIS data.
Notes – 2006
Data is an estimate from provider visit assessments

a. Last Year's Accomplishments
Beginning in 2006, the Idaho Immunization Program modified the information collected in physician's offices during a scheduled quality assurance visit to include the Medicaid status of each patient assessed. The IIP continued to collect and assess this information in 2008.

There is no difference between Medicaid and non-Medicaid children with rates of 84% for the 4:3:1:3:3 (4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B) series.

The IIP also partnered with Medicaid to monitor, develop and implement strategies to increase immunization rates.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing evaluation of the Medicaid population's immunization rate through chart review.				X
2. Ongoing evaluation of the state immunization rate for all children.				X
3. Referral for immunization through WIC link linkage.				X
4. Educate public regarding immunization awareness.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Idaho Immunization Program is continuing to monitor the data collected from the Quality Assurance Reviews. The IIP has established protocols which include collecting the Medicaid status of each patient assessed. This data is entered into Co-CASA and analyzed.

The IIP has developed a strategic plan for improving immunization coverage levels. As part of the strategic plan the IIP has re-developed the Quality Assurance program so that it targets immunization providers that do not have a minimum of 80% coverage level for the 4:3:1:3:3:1 (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella) immunization series. Providers that do not have at least an 80% coverage rate will receive an action plan developed by the Quality Assurance Specialist (QAS) in conjunction with the provider. The Quality Assurance Specialists are communicating the importance of all children receiving immunizations and bringing special attention to missed opportunities. The IIP began rolling out an aggressive media campaign aimed at increasing immunization rates in late 2008. The IIP plans to visit approximately two-thirds of all VFC providers in 2009 with Quality Assurance Reviews.

c. Plan for the Coming Year
The IIP will continue to partner with Medicaid to monitor and implement strategies to increase immunization rates as a result of the difference in coverage levels between non-Medicaid and Medicaid children.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the IIP will re-developed the Quality Assurance program so that it targets immunization providers that do not have a minimum of 80% coverage level for the 4:3:1:3:3:1 (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella) immunization series. The IIP will be conducting Focus Groups around the state to gain insight on ways to increase immunization levels and increase communication with the medical community. The IIP also plans to visit approximately two-thirds of all VFC providers in 2009 with Quality Assurance Reviews (QAR).

The IIP will also continue to implement the strategic plan developed in late 2007 to increase immunization rates for both Medicaid and non-Medicaid children.

State Performance Measure 7: *Percent of 9th – 12th grade students that are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator	7.2	7	7	11	11
Numerator					
Denominator					
Data Source					YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective					

Notes - 2008
YRBS Survey in 2007
Results from: RESULTS OF THE 2007 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2006 SCHOOL HEALTH EDUCATION PROFILE, November 2007
Numerator and denominator not available

Objective rates are set at 0 because of an error at some time in the past an we are unable to adjust to more realistic objectives due to entry constraints imposed by the entry form.

2007 Data entered as most recent available.

Notes - 2007
YRBS Survey in 2007
Results from: RESULTS OF THE 2007 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2006 SCHOOL HEALTH EDUCATION PROFILE, November 2007
Numerator and denominator not available

Objective rates are set at 0 because of an error at some time in the past an we are unable to adjust to more realistic objectives due to entry constraints imposed by the entry form.

Notes - 2006

YRBS not conducted in 2006
Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006
used as estimate for 2006
Numerator and denominator not available

a. Last Year's Accomplishments

The seven public health districts each sent a PAN coordinator to participate in the "Action for Healthy Kids" kick-off meeting in April 2008. The state PAN coordinator and other community partners (Idaho Dairy Council, State Department of Education School Nutrition Program, Idaho Beef Council, and American Heart and Stroke Association) also attended the kick-off meeting. Dayle Hayes, MS, RD, an author, educator and nutrition coach, presented on proper nutrition and effective policies to implement in schools (i.e. recess before lunch, healthy vending machine options, and limiting access to sugar-sweetened beverages in schools) to improve school nutrition environments.

A 2009 "Healthy Habits. Healthy Families." calendar was developed. A new concept for the calendar was approved and incorporated monthly physical activity and nutritional messages along with recipes and healthy life tips. Conducted phone call survey with past calendar recipients to evaluate effectiveness of calendar. Made changes to calendar format based on survey results.

The PAN core messages brochure was translated into Spanish and distributed to local health districts, the Idaho 2-1-1 CareLine and other partners.

The health districts finished the BMI surveillance of Idaho third graders and submitted data to IDHW. IDHW began analyzing data.

IDHW began interviewing for Coordinated School Health Program Specialist to work jointly with the State Department of Education's Coordinated School Health team. The state PAN coordinator attended the Coordinated School Health grantee orientation meeting at the CDC in April 2008. The Program Specialist for Coordinated School Health will begin employment in July 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop media campaign to encourage families to become more active and eat better using Idaho CareLine.		X		
2. Technical assistance will be made available to schools regarding their school wellness policies.				X
3. Formalize a state Physical Activity and Nutrition Alliance/Coalition.				X
4. Conduct BMI surveillance of 3rd graders.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Translate "Healthy Habits. Healthy Families" Handbook into Spanish. Handbook distributed to local health districts, the Idaho 2-1-1 CareLine, and other partners.

Completed analysis of BMI surveillance data and create summary reports. Reports disseminated to health districts and other community partners. State PAN program promotes BMI surveillance project to local media through interviews, radio clips and short videos. Health district PAN coordinators disseminated results locally and to schools that participated in surveillance project.

Completed development of 2009 "Healthy Habits. Healthy Families." calendar. This marketing tool disseminated through local public health districts, community partners, the Idaho 2-1-1 CareLine and through a media campaign. Used 30-second television commercial and a free "Healthy Habits. Healthy Families." calendar.

Provided technical assistance to health districts to reduce obesity through physical activity and healthy eating as needed.

Hired Coordinated School Health Program Specialist in July 2008. Provided input to Coordinated School Health team regarding BMI study. Coordinated School Health is planning a larger BMI surveillance project over the coming year.

Coordinated School Health Program Specialist position vacant as of January 2009.

c. Plan for the Coming Year

Continue BMI surveillance project. This project depends on the outcome of Coordinated School Health's BMI Study to avoid duplicated efforts.

Develop a 2010 "Healthy Habits. Healthy Families." calendar and disseminate. Conduct follow-up survey of 2009 calendar recipients to assess usefulness of calendar. Incorporate messages from coalitions (i.e. Be Outside: Idaho Children and Nature Network) into the calendar.

Shift from education-focused objectives to promoting policy and environmental change in health district PAN contracts. Areas of emphasis will include recess before lunch, after school dance, walking tracks, and healthy vending machine initiatives. Collaborate with Coordinated School Health program.

E. Health Status Indicators

Introduction

The health status indicators provide quite comprehensive demographic information as well as select birth, death and condition information. While all of this information is available elsewhere, it consolidates key measures of significance to the MCH population and program in one area.

This data allows us a comprehensive picture of who current funding is affecting either directly or indirectly. Through the evaluation of outcomes from each of these programs or areas, we are able to weigh the impact of our funding and shift funds as necessary in order to serve the most individuals at highest risk. While this state level data points may assist in program direction, Idaho efforts such as the expanded PRATS survey make it possible for us to look at the issues at a more local level.

Surveillance of these key indicators allows us to monitor our progress in relationship to other MCH programs. The indicators are not particularly useful for evaluation purposes.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6.8	6.7	6.9	6.6	6.4
Numerator	1538	1544	1676	1643	1582
Denominator	22522	23049	24163	25016	24688
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Birth records for Idaho 2007 not final as of entry.

Notes - 2006
Birth records for Idaho 2006 not final as of entry.

Narrative:
/2010/ Data for this indicator are from Idaho birth records. MCH supports and works with the Idaho Perinatal Project and March of Dimes to positively impact this measure. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.1	5.0	5.2	4.9	4.9
Numerator	1104	1119	1213	1201	1169
Denominator	21764	22366	23415	24267	23949
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Birth records for Idaho 2007 not final as of entry.

Notes - 2006
Birth records for Idaho 2006 not finalized at entry.

Narrative:
/2010/ Data for this indicator are from Idaho birth records. MCH supports and works with the Idaho Perinatal Project and March of Dimes to positively impact this measure. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.2	1.1	1.2	1.1	1.0
Numerator	261	257	295	280	249
Denominator	22522	23049	24163	25016	24688
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Birth records for Idaho 2007 not final as of entry.

Notes - 2006
Birth records for Idaho 2006 not finalized at entry.

Narrative:
/2010/ Data for this indicator are from Idaho birth records. MCH supports and works with the Idaho Perinatal Project and March of Dimes to positively impact this measure. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.9	0.7	0.9	0.8	0.7
Numerator	186	166	207	197	178
Denominator	21764	22366	23415	24267	23949
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Birth records for Idaho 2007 not final as of entry.

Notes - 2006
Birth records for Idaho 2006 not finalized at entry.

Narrative:
/2010/ Data for this indicator are from Idaho birth records. MCH supports and works with the Idaho Perinatal Project and March of Dimes to positively impact this measure. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	13.0	12.6	11.7	12.4	12.4
Numerator	40	39	38	42	42
Denominator	308270	308945	325906	339358	339358
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 death records not finalized at time of entry, 2007 final entered as best estimate.

2008 population not available at entry, used 2007 Census population estimate.

Notes - 2007
2007 death records not finalized at time of entry, 2006 final entered as best estimate.

2007 population not available at entry, used 2006 Census population estimate.

Notes - 2006
Death records for Idaho not finalized at entry, used 2005 value as estimate for 2006.

Population totals for 2006 not available, used 2005 as best estimate.

Narrative:
/2010/ Idaho is strengthening it's injury prevention program. MCH funds are supporting this effort and while the program is located in the Bureau of Community and Envrionmental Health, the MCH director works with both the program manager and bureau chief. Idaho does not have a child mortality review board which impacts work in this area. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.5	5.8	4.9	7.7	7.7
Numerator	17	18	16	26	26
Denominator	308270	308945	325906	339358	339358
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 death records not finalized at time of entry, 2007 final entered as best estimate.

2008 population not available at entry, used 2007 Census population estimate.

Notes - 2007
2007 death records not finalized at time of entry, 2006 final entered as best estimate.

2007 population not available at entry, used 2006 Census population estimate.

Notes - 2006
Death records for Idaho not finalized at entry, used 2005 value as estimate for 2006.

Population totals for 2006 not available, used 2005 as best estimate.

Narrative:
/2010/ Idaho is strengthening it's injury prevention program. MCH funds are supporting this effort and while the program is located in the Bureau of Community and Envrionmental Health, the MCH director works with both the program manager and bureau chief. Idaho does not have a child mortality review board which impacts work in this area. Idaho still does not have a primary seat belt law. Policy efforts by MCH partners will continue to strengthen the laws. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	25.4	32.0	29.4	26.9	26.9
Numerator	56	72	64	58	58
Denominator	220875	224678	217461	215401	215401
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 death records not finalized at time of entry, 2007 final entered as best estimate.

2008 population not available at entry, used 2007 Census population estimate.

Notes - 2007
2007 death records not finalized at time of entry, 2006 final entered as best estimate.

2007 population not available at entry, used 2006 Census population estimate.

Notes - 2006

Death records for Idaho not finalized at entry, used 2005 value as estimate for 2006.

Population totals for 2006 not available, used 2005 as best estimate.

Narrative:
/2010/ Idaho is strengthening it's injury prevention program. MCH funds are supporting this effort and while the program is located in the Bureau of Community and Envrionmental Health, the MCH director works with both the program manager and bureau chief. Idaho does not have a child mortality review board which impacts work in this area. Idaho still does not have a primary seat belt law. Policy efforts by MCH partners will continue to strengthen the laws. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	999	999	999	999	999
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
Could not identify a realistic source of data.
Entered 999 so that the form would save.

Notes - 2007
Could not identify a realistic source of data.
Entered 999 so that the form would save.

Notes - 2006
Could not identify a source of data.
Entered 999 so that the form would save.

Narrative:
/2010/ Idaho does not currently have a source for this data. A trauma registry is being developed. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	448.6	406.9	360.5	336.8	310.3
Numerator	1383	1257	1175	1143	1053

Denominator	308270	308945	325906	339358	339358
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Population total not available at this time. Population for 2007 used to calculate rate.

Injuries reflect accidents classified as reportable by Idaho Dept of Transportaion where age of injured, or possibly injured person is known.
Injury count is also preliminary, 2008 data has not been finalized by IDT.

Notes - 2007
Population total not available at this time. Population for 2006 used to calculate rate.

Injuries reflect accidents classified as reportable by Idaho Dept of Transportaion where age of injured, or possibly injured person is known.
Injury count is also preliminary, 2007 data has not been finalized by IDT.

Notes - 2006
Population total not available at this time. Population for 2005 used to calculate rate.

Narrative:
/2010/ The lack of a primary seat belt law contiues to be an area of concern. While the rate has declined as policy has changed, efforts will continue to impact this measure through education and policy. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2,148.1	2,062.5	2,077.6	2,049.7	1,687.1
Numerator	4757	4634	4518	4415	3634
Denominator	221454	224678	217461	215401	215401
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Population total not available at this time. Population for 2007 used to calculate rate.

Injuries reflect accidents classified as reportable by Idaho Dept of Transportaion where age of injured, or possibly injured person is known.
Injury count is also preliminary, 2008 data has not been finalized by IDT.

Notes - 2007
Population total not available at this time. Population for 2006 used to calculate rate.

Injuries reflect accidents classified as reportable by Idaho Dept of Transportaion where age of injured, or possibly injured person is known.
Injury count is also preliminary, 2007 data has not been finalized by IDT.

Notes - 2006
Population not available at this time. Used 2005 population as estimate for denominator.

Narrative:
/2010/ The lack of a primary seat belt law contiues to be an area of concern. While the rate has declined as policy has changed, efforts will continue to impact this measure through education and policy. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	14.2	14.1	15.2	17.8	21.8
Numerator	752	771	829	972	1189
Denominator	53054	54649	54649	54561	54561
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Population estimate for 2007 not available, 2006 population estimate used.

Notes - 2006
Population estimate for 2006 not available, 2005 population estimate used.

Narrative:
/2010/ Chlamydia rates in this population continue to increase. Federal STD funding has been level. State general funds ($140,000) for STD education was discontinued in 2008. Considerable effort has been made to reach youth through websites and other means that they relate to. Input from youth groups and the Hispanic community have made messages more targeted and meaningful. These efforts and work with local agencies to provide testing and treatment will continue. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	5.7	5.5	6.4	6.7	7.3
Numerator	1364	1349	1565	1647	1800
Denominator	238590	244149	244149	245389	245389
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Population estimate for 2008 not available at entry time, 2007 population estimate used for denominator

Notes - 2007
2007 population estimate not available, 2006 population estimate used.

Notes - 2006
2006 population estimate not available, 2005 population estimate used.

Narrative:
/2010/ While services to this age range are provided through Title X contracts with local agencies, the focus for outreach has been to teens through age 24. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	24352	22421	338	358	312	38	885	0
Children 1 through 4	94278	87068	1399	1551	1291	145	2824	0
Children 5 through 9	111753	102744	2014	1947	1404	186	3458	0
Children 10 through 14	108975	101179	1644	1848	1137	162	3005	0
Children 15 through 19	110959	104398	1146	1969	879	162	2405	0
Children 20 through 24	104442	98495	1197	1730	1015	197	1808	0
Children 0 through 24	554759	516305	7738	9403	6038	890	14385	0

Notes - 2010
Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Narrative:
/2010/ Cenus data. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	20474	3878	0
Children 1 through 4	79405	14873	0
Children 5 through 9	94903	16850	0
Children 10 through 14	93409	15566	0
Children 15 through 19	97872	13087	0
Children 20 through 24	92584	11858	0
Children 0 through 24	478647	76112	0

Notes - 2010
Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Narrative:
/2010/ Census data. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**

Women < 15	17	11	0	1	0	0	2	3
Women 15 through 17	628	451	7	14	1	0	20	135
Women 18 through 19	1632	1371	6	44	6	1	45	159
Women 20 through 34	20208	18045	89	257	251	37	312	1217
Women 35 or older	2534	2266	11	26	61	1	23	146
Women of all ages	25019	22144	113	342	319	39	402	1660

Notes - 2010

Narrative:
/2010/ Data from Idaho birth certificates. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	6	10	1
Women 15 through 17	348	276	4
Women 18 through 19	1245	378	9
Women 20 through 34	17290	2853	65
Women 35 or older	2174	347	13
Women of all ages	21063	3864	92

Notes - 2010

Narrative:
/2010/ Data from Idaho birth certificates. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	169	143	2	4	4	0	3	13
Children 1 through 4	31	27	0	2	0	0	0	2
Children 5 through 9	11	8	0	0	0	0	0	3

Children 10 through 14	27	25	0	1	0	0	1	0
Children 15 through 19	83	70	0	3	1	0	1	8
Children 20 through 24	99	87	0	4	2	0	2	4
Children 0 through 24	420	360	2	14	7	0	7	30

Notes - 2010

Narrative:
/2010/ Idaho death certificate data. Idaho does not have a child mortality review team making it difficult to identify specifics on these deaths. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	139	30	0
Children 1 through 4	25	6	0
Children 5 through 9	5	6	0
Children 10 through 14	25	2	0
Children 15 through 19	69	14	0
Children 20 through 24	91	8	0
Children 0 through 24	354	66	0

Notes - 2010

Narrative:
/2010/ Idaho death certificate data. Idaho does not have a child mortality review team making it difficult to identify specifics on these deaths. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	450317	417810	6541	7673	5023	693	12577	0	2007
Percent in household headed by	26.1	24.6	0.0	0.0	0.0	0.0	0.0	0.0	2008

single parent									
Percent in TANF (Grant) families	0.9	0.9	2.1	2.5	0.1	0.7	0.0	0.0	2008
Number enrolled in Medicaid	142063	135442	2220	3204	957	240	0	0	2008
Number enrolled in SCHIP	42583	41232	412	629	249	61	0	0	2008
Number living in foster home care	1794	1533	28	135	0	2	96	0	2007
Number enrolled in food stamp program	96048	90933	1931	2383	619	182	0	0	2008
Number enrolled in WIC	11757	10629	129	548	104	43	304	0	2008
Rate (per 100,000) of juvenile crime arrests	5922.5	5885.2	6268.2	6659.7	2349.2	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.6	2.3	2.5	3.9	1.9	0.0	0.0	0.0	2008

Notes - 2010
Based on results from Census current population survey at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html with race, age and kind of family. Percentages
not reported for Black, AI/AN, Asian, NHOPI because small sample sizes yield unreliable estimates. Other or unknown race not reported in census generated race table.

More than one race or other/unknown race information not collected/reported by responsible agency.

More than one race or other/unknown race information not collected/reported by responsible agency.

More than one race or other/unknown race information not collected/reported by responsible agency.

More than one race information not collected/reported by responsible agency

Based on records submitted to PEDNSS

More than one race race information not collected/reported by responsible agency. Pacific Isalander included in Asian. About 3.9 percent of all arrests are listed as unknown race; arrest rate cannot be calculated as we do not have a population denominator for unknown race.

More than one race or other/unknown race information not collected/reported by responsible agency. Pacific Islander included in Asian. For school year 2007-2008

Based on rates provided by Brian Baldwin.

Narrative:
/2010/ Program data. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	386063	64254	0	2007
Percent in household headed by single parent	23.2	43.1	0.0	2008
Percent in TANF (Grant) families	0.8	1.3	0.0	2008
Number enrolled in Medicaid	113134	28929	0	2008
Number enrolled in SCHIP	31966	10617	0	2008
Number living in foster home care	1481	313	0	2007
Number enrolled in food stamp program	75591	20457	0	2008
Number enrolled in WIC	8808	3669	0	2008
Rate (per 100,000) of juvenile crime arrests	5613.1	5288.4	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.3	5.2	0.0	2008

Notes - 2010
Based on results from Census current population survey at http://www.census.gov/hhes/www/cpstc/cps_table_creator.html with race, age and kind of family.

About 6.0 percent of arrests are listed as unknown ethnicity; arrest rate cannot be calculated as we do not have a population denominator for unknown ethnicity.

Reporting agency does not report on ethnicty not reported. For school year 2007-2008.

Narrative:
/2010/ Program data. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	0
Living in urban areas	318114
Living in rural areas	104877
Living in frontier areas	27326
Total - all children 0 through 19	450317

Notes - 2010
Source: Census Bureau, July 1, 2007 population estimates. Idaho has no designated metropolitan areas

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Source: Census Bureau, July 1, 2007 population estimates.

Narrative:
/2010/ Rurality and geographic barriers continue to be challenges in accessing healthcare in Idaho. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1500539.0
Percent Below: 50% of poverty	4.0
100% of poverty	10.0
200% of poverty	30.1

Notes - 2010
Results are from Census website Current Population Survey estimate for 2008.

Results are from Census website Current Population Survey estimate for 2008.

Results are from Census website Current Population Survey estimate for 2008.

Narrative:
/2010/ The current national economic situation is likely to impact this provisional data in a negative manner. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	462965.0
Percent Below: 50% of poverty	6.5
100% of poverty	13.0
200% of poverty	39.0

Notes - 2010
Population total is as provided by Census Current Population Survey for 2008.

Narrative:
/2010/ The current national economic situation is likely to impact this provisional data in a negative manner. //2010//

F. Other Program Activities

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and management.

The CSHP Program will continue to provide biannual regional PKU clinics in Boise, Idaho Falls, and Spokane, Washington. Idaho has made the decision to consolidate PKU services under one physician in an effort to provide consistent care from birth through 18. Dr. Ron Scott will discontinue staffing Idaho clinics during the summer of 2005 and Dr. Cary Harding from Oregon Health and Science University will be taking his place. Families receive initial consultation from OHSU and Dr. Harding already comes to Idaho to see children with other metabolic disorders.
/2010/ As in previous years, CSHP provides quarterly metabolic clinics in Boise, and semi-annual clinics in Idaho Falls, and Coeur d'Alene/Lewiston. Dr. Cary Harding of the Oregon Health and Sciences University continues to conduct these clinics, with the support of his Metabolic Nutritionist, Martha Duffy. //2010//

/2009/ The CSHP Program provides quarterly regional metabolic clinics in Boise, Idaho Falls, and Coeur d'Alene/Lewiston. Dr. Cary Harding continues to conduct these clinics, with the support of his Metabolic Nutritionist, Martha Duffy. //2009//

The MCH research analyst, Greg Seganos, and the MCH special Projects Coordinator, Traci Berreth, have recently completed the publication of the Bureau of Clinical and Preventive Services outcome performance measures. This document will be updated quarterly and will provide a method for the MCH programs to monitor performance on a statewide basis as well as provide information to the Department's administration in regard to the Bureau's contribution to the Department's goal of improving health status.

/2008/ MCH Director, Dieuwke A. Spencer, and MCH research analyst, Ward Ballard, will continue to compile and analyze outcome performance measures quarterly and annually. //2008//

The Idaho Fit Kids Project is a year long pilot project focusing on the use of BMI as a predictor of risk for overweight in children and providing families with helpful tips on health. The Division of Health contracted with the District Health Departments in the state to provide training to pediatrician and family practice offices in their service area. The trainings include factual information on BMI, ideas for incorporating BMI into practice and how to provide parents with guidance related to their child's healthy growth.
Each Health District has been contracted to provide up to 25 trainings between March 1, 2005 and October 31, 2005. The Division of Health provided training to the Health Districts regarding this project in January 2005.

Through the trainings provided by the Health Districts, physician offices will receive "Idaho Fit Kids" handouts for patients, CDC growth grids, and a card for families to mail to the Department of Health and Welfare if they would like to receive more information related to healthy growth. The families who return the request for information card will receive a series of 6 newsletters in the mail from the Division of Health. The newsletters will contain tips on eating healthy and activity.

To date, the Health Districts have trained over 30 physician offices in the state.

Evaluation will take place in January 2006 and will include:

1. Chart review of physician offices which received training to measure whether or not BMI was assessed.

2. A written survey will be mailed to families who requested more information for the purpose of determining if they found the information helpful.

3. Physician offices will be asked to complete a brief survey during January 2006 related to the project.

/2007/ Through the Idaho Fit Kids Project the Health Districts trained 141 physician offices in the state. 125 families requested additional information through a series of newsletters. Evaluation is currently underway and will be completed by the end of calendar year 2006.

1. Chart reviews are being conducted in the physician offices which received the training to measure whether or not BMI was assessed.
2. Physician offices are being asked a few questions regarding the project using an interview format. This interview is occurring at the same time of the chart review
3. Written surveys are being distributed to the families who requested more information for the purpose of determining if they found the information helpful.

Follow-up projects will be considered based on the project evaluation results. //2007//

The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 34,190 children grades 1-6 in 2004. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 51,747.

/2007/ The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 33,754 children grades 1-6 in 2005. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 56,795. //2007//

The MCH Oral Health Program continues to fund early childhood caries (ECC) prevention and fluoride varnish projects for WIC clients, Head Start children, and children who are Medicaid/CHIP eligible. During 2005, 13,323 children received preventive dental services, including 3,020 who received fluoride varnish applications, and 7,382 parents, teachers, dental and medical health professionals served through education and community outreach efforts.

The State Oral Health Collaborative Systems (SOHCS) Grant to integrate oral health with well child care was implemented during 2005 in southwest Idaho. Trainings in early childhood caries prevention and fluoride varnish application were provided to 36 dental and 93 medical professionals, including the Family Practice Residency of Idaho faculty, residents and nursing staff; St. Luke's Cystic Fibrosis Clinic nurses; the Ada Canyon Medical Education Consortium; health district immunization clinic nurses; and private practice dentists, physicians and staff. The project also included media outreach to an estimated 51,120 women age 18-34 years through public service announcements developed in partnership with Idaho Oral Health Alliance members.

The Oral Health Program helped convene the Idaho Head Start Oral Health Forum in November 2004. Forum follow-up included development of an Idaho Head Start Oral Health Action Plan and motivational interview trainings with a focus on oral health, presented by Dr. Philip Weinstein, University of Washington, during September 2005. The motivational interview trainings were held in six population areas of the state and were attended by 244 Head Start, WIC and district dental

staff. A smile survey of Idaho Head Start children is currently underway.

The 2005 Idaho State Smile Survey collected oral health data on 6,300 kindergarten, third and sixth grade students.

G. Technical Assistance

The Idaho Oral Health Program may request technical assistance to support the prenatal oral health project that is currently in the planning stages for implementation in FY 2006.

The goal of the project is to integrate oral health with prenatal care. The target population is pregnant women, particularly those served through the Medicaid Program. The Idaho Medicaid Program pays for approximately 40% of all deliveries. Efforts will be made to engage both medical and dental care providers in the effort. Project partners will include the Medicaid Healthy Connections Program, the District WIC and Oral Health Programs, as well as representatives of professional and community organizations with an interest in maternal and child health.

Project objectives are to increase awareness of the link between oral health and birth outcomes and increase access to periodontal care that can improve pregnancy outcomes. Medicaid data on dental access and costs associated with deliveries and preterm births will serve as a baseline for project evaluation.

Plans are to bring together key stakeholders for a brainstorming session to present the project proposal, get input, and form a state leadership team. If a technical assistance request is submitted, it will be to bring in a consultant to participate in the brainstorming session, advise the leadership team, and to provide continuing education for project partners on the science linking oral health to birth outcomes and the safety of providing dental services during pregnancy. We anticipate both state and district level trainings could require technical assistance.

/2009/The Children's Special Health Program (CSHP) is unsure how to approach trying to impact Performance Measure #3 (Medical Home), and would appriciate some technical assistance on the subject.

Idaho is interested in technical assistance with strategies and methods to obtain unduplicated counts across agencies.2009//

V. Budget Narrative

A. Expenditures

Annual Expenditures

For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and related notes.

Funds used for state match during federal fiscal year 2008 are from the Immunization Program. State general funds in the amount of $4,104,964 were used to purchase vaccine for children and support the immunization registry. This amount exceeds the required 75 percent match of $2,751,768. This funding commitment allowed the state to maintain universal status where all children regardless of income or insurance status have access to free vaccine.

The expenditures in FFY 08 that were directed to Pregnant Women including 25% of the MCH administrative budget ($34,546), Pregnancy Risk Assessment Tracking system ($53,000), 25% of the Office of Epidemiology and Food Protection MCH budget ($51,594), 20% of the Reproductive Health MCH budget ($131,263), and 25% of the Idaho CareLine MCH budget ($14,352).

Funds used in FFY 08 for Infants < 1 Year Old included 25% of the MCH administrative budget ($34,546), 25% of the Office of Epidemiology and Food Protection MCH budget ($51,594), 25% of the Idaho CareLine MCH budget ($14,352), 50% of the Immunization Program state and local funds used for block grant match ($1,617,851), and newborn hearing screening ($19,455).

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($34,546), 25% of the Office of Epidemiology and Food Protection MCH budget ($51,594), 25% of the Idaho CareLine MCH budget ($14,352), 50% of the Immunization Program state and local funds used for block grant match ($1,617,851), the Oral Health Program ($352,345), and 40% of the MCH budget for Reproductive Health ($262,527).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget ($34,546), 25% of the Office of Epidemiology and Food Protection MCH budget ($51,594), 25% of the Idaho CareLine MCH budget ($14,352), the Genetics Program ($307,477) and the Children's Special Health Program ($1,065,362).

40% or $262,527 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age. And $282,743 in indirects was included in expenditures for the Administrative budget.

FFY 08 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the Genetics Program budget ($276,729), the Reproductive Health Program Budget ($656,317) and the Children's Special Health Program budget ($1,065,362). The two programs included under enabling services was the Idaho CareLine ($57,408) and 10% ($1,729) of the MCH money supporting the STD program. Programs included in the Population-Based Services category were Oral Health ($352,345), Immunizations ($3,235,702 - state and local match), and Newborn Hearing Screening ($19,455).

Programs included under infrastructure Building Services included: MCH Administration ($138,183), Pregnancy Risk Assessment Tracking System ($53,000), Office of Epidemiology and Food Protection ($206,376), 10% of the Genetics Program ($30,748), and the indirect budget ($282,743).

Total reported MCH expenditures for Idaho during FFY 08 are $6,420,792.

B. Budget

To meet the match requirement the state will be utilizing $2,427,626 in state general funds.

The priority areas for Idaho are children with special health care needs, reproductive health for young women, oral health of children, epidemiology services and genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. In fact, those two programs alone account for 34% of the block grant funds. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Injury Prevention.

An area we had focused additional funding on was Idaho's Pregnancy Risk Assessment Survey. Data from previous years provided an overview of perinatal issues statewide, but by increasing the sample size we are now able to identify trends in specific areas of the state. We use this valuable data to guide program direction and project development. In FFY10, PRATS will be funded with receipts, not MCH funds. MCH funds will continue to be used to fund a full-time research analyst dedicated to MCH programs.

MCH funds previously provided to the Idaho Perinatal Project to support educational efforts with lay midwives for the best possible birth outcomes for Idaho babies will not be contracted this year. IPP and MCH had estimated a need for four years of funding and this was met. Additionally, the 2009 legislature passed a bill requiring the licensure of midwives in Idaho. Rules will be promulgated in 2010.

Federal fiscal year 2010 will also see MCH funds supporting an injury prevention program. This has been an area in which Idaho has been weak for a number of years. Decreased funding for poison control efforts resulted in a realignment of MCH funds to help meet this need in our very rural state. Some of these funds were previously used to support the newborn hearing screening program by supporting audiologists in attending continuing education opportunities.

One area that the State has made progress on over the past year is transitioning Idaho's Children Special Health Program away from being primarily an insurance plan to focusing on care coordination for the uninsured and ensuring reasonable access to specialty care throughout the state. The final clinic, Genetics, which was being administered and staffed by the state was contracted to St. Luke's Children's Specialty Hospital. Contracting this program to the same staff managing CSHCN will result in improved efficiencies.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.